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**INVESTIGATING THE UTILITY OF A SELF-ASSESSMENT
TOOL IN THE 'OVER 75S'.**

By

Sandra Birnie

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Science in Professional Practice

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DECLARATION

The work is original and has not been submitted previously in support of any qualification or course.

Signed:

Date:

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ABBREVIATIONS

ADLs	Activities of Daily Living
BNI	British National Index
CAP	Client Assessment Protocol
CINAHL	Cumulative Index of Nursing and Allied Health
DH	Department of Health
GMS	General Medical Services
GP	General Practitioner
HMO	Health Maintenance Organisation
MDS	Minimum Data Set
MDS-HC	Minimum Data set – Home Care version
NHS	National Health Service
NSF	National Service Framework
PCG	Primary Care Group
PCT	Primary Care Trust
QOL	Quality of Life
R&D	Research and Development
SAP	Single Assessment Process
UK	United Kingdom
<i>interRAI</i>	<p>an international collaboration of gerontologists, academics and health care professionals who aim to promote comprehensive, standardised assessment of older people. In addition to improving the quality of assessment and quality of care, these assessments can provide crucial information about the needs of the elderly population.</p> <p><i>interRAI</i> UK has been established to promote the care assessment needs of older people in the United Kingdom. It is a registered charity (charity number 1083393) and has the support of CHSS at the University of Kent, PSSRU at the</p>

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Chapter One

Introduction

Since the 1990 General Practice service agreement, general practitioners (GPs) have been obliged to offer all patients over the age of 75 years, an annual health check (DH, 1989; 1990). This was part of a wider remit to ensure that health promotion and illness prevention were part of general medical services explicitly and was prompted by the perception that older people living in the community experience a range of unmet health and social needs (Garrett, 1992). The agreement was to not only target those patients who were able to attend the GP surgery, but also the housebound and those living in residential and nursing homes.

The requirement to offer an annual health check to these patients was, and has remained highly controversial (Iliffe et al, 1997). Health checks for the 'over 75s' were introduced despite weak and inconclusive evidence of practical benefit for older people (Arthur, 2000). There was also a lack of provision of adequate resources to ensure this was carried out across the country (McIntosh et al, 1988; Iliffe et al, 1991). Buxton (2000) identified both anecdotal and research based evidence highlighting that health checks for the elderly are widely ignored by health professionals (Buxton, 2000). This was identified as being mainly due to inconclusive evidence of any research with a sound scientific basis which supported the effectiveness of such check ups (Buxton, 2000).

It is well documented that with increasing years, there is a rise in the incidence of, amongst others, circulatory diseases; cancers; dementia; osteoarthritis; oral health

problems; diabetes and cataracts; and this is more marked in the over 85 age group (DH, 2001; Seddon, 1998). When the GP service agreement was introduced, there was no standard format for the 'over 75' health check, and therefore no specific areas identified as necessary to monitor on an annual basis.

The National Service Framework (NSF) for Older People was designed to ensure the delivery of both appropriate and high quality services and further stipulated the elimination of 'ageism' (DH, 2001). However, it also requires that health professionals promote older peoples' health and independence. This is in line with the initial concept of the 1990 GP agreement, since the cornerstone of the 'over 75' health check was an emphasis on health promotion and prevention of functional disability, with the aim of preventing or reducing disability, rather than just screening for specific diseases (DH, 1989).

Standard Two of the NSF describes a Single Assessment Process (SAP), the aim of which is to raise assessment standards and promote consistency across the country as well as keeping any assessment in proportion to the needs of the patient on an individual basis. Gudmundsson and Carnes (1996) suggest that there should be a way of identifying those patients who require assessment rather than a 'carte blanche' approach based on age, which is uneconomic use of NHS resources. This is the starting point of SAP (Appendix 1).

Guidance from the Department of Health on SAP (DH, 2002) does not affect the obligation on GPs to offer a health check on at least an annual basis, to all people aged 75 and over on their practice list. Further guidance on the 'over 75' health check

and the relationship with SAP was due to be issued in 2003, but to date, none has been forthcoming. Nonetheless, as previous evidence has highlighted, the whole process around the 'over 75' health check is in need of review.

Local Context

Within Cheshire West Primary Care Trust (PCT) there are twenty-six GP practices serving a mixture of urban and rural areas. They cover some of the highest wards in the country for both deprivation at one end and affluence at the other – for example, Blacon, College and Dee Point are in the top 10% of wards nationally on the index of Multiple Deprivation 2000, whereas in a number of city and rural areas there are some very affluent populations (Noakes, 2002). Each practice has an average of 7% of their population over the age of 75 years (range 3 – 10%). In line with the general national statistics, the elderly population within Cheshire is set to continue to rise over the next decade (National Statistics Online, 2004). However, in Cheshire the rise in the 'over 75' population over the next ten years is predicted to be higher than the national figures (Seddon, 1998). Indeed, in Chester already, the population over the age of 75 years at the time of the 2001 census was 8.1% as opposed to the England and Wales figure of 7.6% (National Statistics Online, 2004).

In 2001, the author carried out a survey regarding health promotion and health checks for the elderly across general practices in Chester city (Birnie, 2001). The survey suggested that the majority of practices monitor the health of their elderly population to some extent. For a few practices, this is proactive and extensive, although the services provided varied widely, ranging from no care at all aimed specifically at the elderly to, in one practice, a comprehensive elderly health promotion service led by a

dedicated nurse. The majority of professionals consulted felt that elderly health checks should not be thought of as a separate entity to other types of health monitoring and should be integrated wherever possible (Birnie 2001).

Anecdotal evidence from conversations with those professionals who carry out the 'over 75' health checks, suggests that in practices in Chester where 'over 75' health checks are offered, those who attend are often already proactive about maintaining and promoting their own health, although this is not always the case. There appeared to be little in place to ensure that all patients are assessed formally, and the view of those professionals was that those who are not presently seen in this way are people who would benefit from health promotion and intervention to prevent further deterioration and avert possible crises (Donald and Bulitt, 1998). It would seem, anecdotally at least, that in a number of practices patients who would probably benefit the most from a health check never receive one. It is possible that this can lead to inequities in care provision whereby those people who are more self motivated in terms of their health needs are more likely to receive care earlier and therefore remain healthy; whilst those who do not normally present themselves at their GP surgery or actively seek health care, may become ill or require crisis intervention. The existing policy is clearly not adequate to address those most in need.

Background

In 2001, Cheshire County Council received a grant for projects that considered aspects of SAP (Standard Two, NSF for Older People, 2001). The three projects across Cheshire considered the feasibility of implementing SAP for older people using an electronic health record – the Minimum Data Set–Home Care (MDS-HC)

(AIS, 2002).

The MDS-HC provides a complete electronic based assessment system covering the four types of assessment levels as outlined in SAP and is designed to be used by health or social care professionals (AIS, 2002a; Dutton, 2002). More recently, the MDS-HC has been anglicised for use in this country (*InterRAI-UK*), and is recommended by the Department of Health for consideration for use by local authorities implementing SAP. Previous knowledge of the system led to it being considered as the preferred tool for SAP in Cheshire.

The project in west Cheshire concentrated on the 'Contact' assessment (Dutton, 2002; Miller et al, 2004). The seven 'contact' assessment questions in the MDS-HC assessment proforma provide initial indicators of need for further assessment or intervention. The MDS-HC Contact assessment questions identify both ability and motivation of older people and have previously been researched as being valid and reliable at identifying the need for further assessment or intervention (Appendix 2 & 3), (AIS, 2002).

For the purposes of the pilot project, the questions were produced in a self-assessment format, in order to compare the results of this with the outcomes of face-to-face consultation (Dutton, 2002). Prior consultation with an older persons' reference group ensured the clarity of the questions for older people (Dutton, 2002).

The researcher had access to the health and social services records of all older people included in the project in order to compare the results of the questionnaire, with the

outcomes of the consultations. It was interesting to note that those participants who had been identified as 'self-reliant' using the questionnaire, actually had all their needs met through the consultation, irrespective of whether they had contacted their GP or social services. On the other hand, those participants who had been identified as 'not self-reliant' were likely to be already known to a number of services and were in the process of receiving ongoing assessment and support, confirming the use of the MDS-HC 'Contact' assessment as a reliable indicator of need (Dutton, 2002).

It was in light of the above pilot project results, and the earlier work completed locally regarding approaches to health care in the 'over 75s', that the author was encouraged to consider the relationship between SAP and the 'over 75' health check locally, in advance of any guidance from the Department of Health on the subject (DH, 2002).

The original thought behind this study was a view that there ought to be a means in primary care of promoting the health of the local elderly population and of avoiding crisis intervention. This should be achievable through supporting the vulnerable, whilst at the same time ensuring those who are fit and well stay that way. Anecdotal evidence suggests that it is an inefficient use of resources to perform a full health and social care assessment on an annual basis to all 'over 75s' in a practice population, since there are many older people who remain fit and well. Conversely, however, there is an element of the population who do not seek help when they need it (Gudmundsson and Carnes, 1996). Consequently, best practice would seem to indicate the need for a targeted approach, in order to 'screen out' those people who are vulnerable and likely to have health and social care needs requiring professional intervention, thereby moving towards assessing those health needs, and building up

knowledge of the elderly patients in a practice population. This, in turn, should enable practices to consider proactive health promotion to reduce crisis intervention by utilising practice resources efficiently and effectively.

Initial thoughts were to run a pilot project with one or two practices across the PCT area. However, following discussions with the PCT Research and Development (R&D) Department, it was decided that there was more to be gained in terms of financial support for the practices involved, credibility for future roll out across the PCT, and an ability to learn so much more about the process, by running it as a research project, with the support of the R&D department.

The research questions

There are a number of questions to be explored: -

Does a self-assessment screening tool identify those patients aged 75 and over in a general practice setting who require further assessment of their health needs?

Is this an efficient method for identifying those patients aged 75 and over who require further assessment of their health needs?

Is this form of screening and targeting assessment acceptable to patients in primary care?

What influences how older people perceive their own health needs?

Aims

The aims of the proposed study therefore, are: -

- To evaluate the validity of a self-assessment screening tool for the selection of patients aged 75 and over, who require further assessment of their health needs.
- To promote older people's health and independence through preventing deterioration and managing crises by targeting assessment and active care management matched to individual circumstances.
- To ascertain the patients' perspective of using this approach.
- To raise the awareness within practices of patients who may be vulnerable or at risk.
- To identify the impact of such an approach on existing practice resources.

Anticipated benefits and outcomes

The outcomes from the project will inform future assessment and health promotion for the 'over 75' population in general practice across Cheshire West PCT, in line with the guidance around SAP and also enable practices to develop a profile of their vulnerable elderly.

It is anticipated that the self-assessment questionnaire will: -

- enable older people to take ownership of, and consider their own health needs in terms of health promotion and further assessment and/or interventions which they may feel they need; and

- enable practices to make decisions about which patients require assessment of their needs by using a targeted approach which utilises practice resources more efficiently and effectively.

The study will also inform practice with regard to 'case finding' patients who need to be part of SAP, by highlighting individuals with unmet needs requiring further assessment. It would seem sensible for all 'over 75' health checks to mirror the domains required by the Department of Health which constitute the 'overview' assessment of SAP, as used in this study, in order to provide a seamless service for the patient.

Chapter Two

Literature Review

Introduction

The aim of a literature review is to look at work that has already been done in a particular area, to search for the major concepts, conclusions, theories and arguments. It provides the context for the current research project. The literature discussed in this review has been obtained from several sources – namely books, journal articles, government documents and the internet. Databases Medline, Proquest and Cinahl were searched from disciplines including health and social science. Like much academic work, a literature review can never be complete as new evidence is being produced all the time and it is necessary to make the decision early on about limiting the scope of the search; what to include and what to discard (Punch, 2000). The inclusion criterion for this project was therefore selected as 1990 to the present day 2005, with articles written in English only. Key search terms included elderly health checks; health screening; ‘over 75’ health assessments; targeted assessment; GP contract; Single Assessment Process and geriatric screening. Literature identified from these searches has been collated and reviewed in order to present a comprehensive overview of the subject area

It was discussed earlier, that since the 1990 GP agreement, there has been an obligation on the part of GP practices to offer an ‘over 75’ health check to their practice population. Although there is nothing explicit in the new General Medical Services (GMS) contract (DH, 2003) which necessitates GPs to continue to offer an ‘over 75’ health check, it remains an implicit element of the NSF for Older People

(DH, 2001) and is an anticipated method of 'case finding' as regards SAP. Due to the controversy that arose out of the 1990 GP agreement, inevitably, there have been numerous articles written on the subject, with varying viewpoints. Some have considered the use of postal questionnaires as a screening tool for older people (Hébert et al, 1996; Brody et al, 1997; Smeeth et al, 2001); some have explored self report screening (Kempen et al, 1996; Benyamini et al, 2000); and yet other articles which have discussed the merits (or otherwise) of proactive holistic assessment of all over 75 year olds in a practice population (Hedley et al, 1986; McIntosh et al, 1988; Iliffe et al, 1991; Iliffe et al, 1999; Hébert et al, 2001).

The 'over 75' health check

Guidance from the Department of Health (DH, 2002) has indicated that localities should consider the 'over 75' health check as a method of case finding, whilst at the same time, reviewing the extent of the health check in light of the domains of SAP (Appendix 4).

In 2000, van Haastregt and colleagues performed a systematic review of fifteen randomised controlled trials retrieved from Medline, Embase and the Cochrane register, to assess the effects of preventive home visits to the elderly living in the community (van Haastregt et al, 2000). It is interesting to note that the research failed to find any clear evidence to support the effectiveness of preventive home visits to elderly people in the community in all trials except the trial that was aimed at the selection of elderly people with specific risk factors for health problems. Although the authors maintain that this stresses the importance of choosing the right target population in future programmes for home visits, it needs to be highlighted that this

assumption has been made on the strength of only one trial of its' type and needs to be considered further.

A later study by Gould et al (Gould, Iliffe & Wallace, 2000) followed a similar vein to that completed by Birnie (2001), in that it explored how health checks for older people were carried out in various primary care premises. Also, like Birnie, Gould et al (2000) discovered that there were a number of different models being used across the country, although in the majority of cases, (11 out of 14), it was nurses who carried out the health checks. Models themselves seemed to evolve dependent on individual practices and the view of staff within that practice. However, there did appear to be a commonality in terms of including an initial approach to the older person by letter enclosing a self/carer-completed questionnaire, use of agreed criteria for follow up of questionnaire responses and of non-responders, and to have clear referral guidelines.

Philp and colleagues took this a stage further, building on this evidence by aiming to develop a best-practice assessment tool for assessing older people in primary care (Philp et al, 2001). The project looked at the comparative benefits of using a number of different tools to assess the health needs of older people across nine GP practices in Sheffield. The best practice model was the use of a standardized instrument (EASY-care) in the context of an 'over 75' health check (Philp et al, 2001). This assessment tool has been developed specifically as a comprehensive geriatric assessment and, as such, takes into account all the domains required of a 'single' assessment. 'Best practice' criteria in this instance considered criteria such as user acceptability and the assessment protocols were modified to meet these criteria, helping to develop the

standardised assessment. There are a number of points to reflect upon within this study, including the assumption that this process would be used for all older patients in a practice as part of an 'over 75' health check. It has already been highlighted that this is not a universally accepted approach and is not likely to be acceptable to a number of practices. The mean time recorded for completing such an assessment was identified at 39 minutes – a large amount of time to be found within busy practice hours, especially for a practice with a large elderly population. Although this project has attempted to address the question of standardising the 'over 75' health check, the author would argue that the costs in terms of staff time and effort, of completing such an assessment for each individual over the age of 75 in a practice population, would prove prohibitive to many practices.

This is also borne out by Iliffe et al (Iliffe et al, 1991) who costed out that in a practice of 2000 patients with 130 aged 75 or over, the primary health care team would need over 150 hours of face to face contact on an annual basis with those patients to fulfil the contractual agreements of the GP contract. Although Iliffe's study was very small, he also identified that with this particular practice population, the time and effort involved produced little new information and was therefore an inefficient use of resources (Iliffe et al, 1991). It is important to note, however, that a number of other authors identified not only the need for a standardised approach to the assessment of older people, but also for a more holistic approach to individuals and their health with greater emphasis on health promotion and prevention of functional disability, prior to the publication of the NSF for Older People (McGarry, 1999; Walters et al, 2000).

Since the introduction of the NSF for Older People (DH, 2001) there has been a rapid

increase in the development of 'standardised' assessment tools to meet the criteria laid down by SAP (DH, 2001; 2002). A number of these have, in recent years, developed subsets of the complete assessment tool which can be used as a 'contact' assessment in order to help practitioners make a decision as to under which circumstances there may be a need to complete the full assessment (Philp et al, 2001; Carpenter, 2004). This will be discussed further in the next section.

Targeting health assessments

In her study of the implementation of holistic health checks for the older population in Melton Mowbray, McGarry (1999) recognised that an average of one in four health checks resulted in the identification of an unmet need or problem, requiring subsequent referral to other primary care services or agencies (McGarry, 1999). This confirmed the results of the earlier study completed by Philp et al in 1991, in which, the length of time spent seeing each patient in this way, actually yielded very limited new information that required further effective medical or social intervention (Philp et al, 1991). However, McGarry's study has added interest, in that the longitudinal dataset of older people built up over a period of eight years, lends itself to the potential for targeting future health assessments by utilising data from previous rounds to prioritise which patients need to be seen (McGarry, 1999).

The benefits or otherwise of targeted assessment have been the subject of a number of researchers ever since the introduction of the 'over 75' health check and opinions differ over the matter. A cluster-randomised trial in 106 general practices across the UK completed by Fletcher et al in 2004, compared (a) universal versus targeted assessment and (b) subsequent management by hospital outpatient geriatric team

versus the primary care team. They found very little difference in terms of patient outcomes (Fletcher et al, 2004). The participants comprised all patients who were 75 or over during the year of the study, registered with one of the participating practices, excluding anyone in long term nursing care or with terminal illness. All participants initially received a brief assessment. In the universal group, all participants then underwent a detailed assessment. In the targeted group, only participants with three or more problems from the brief assessment or any one of four serious symptoms (not identified in the study) had the detailed assessment. The participating practices were randomly chosen for either universal assessment or targeted assessment. Each practice was then further assigned to either primary care or geriatric team and practices were equally distributed between the groups of the trial with similar characteristics and participation rates.

The researchers had already identified prior to the trial, that none of the participating practices were carrying out rigorous assessments, which reduces the possibility of bias towards one or more of the practices. This particular study mainly took into account mortality rates and hospital admissions as outcome measures and provided no follow up on the outcomes of any onward referrals made as a result of the detailed assessment. However, the value of this study is in the fact that the results showed that the proportion of participants who met the criteria for onward referral was higher in the targeted group (61%) than in the universal group (34%), which may give some credence to the use of a targeted approach to assessments in this age group.

A further point to take into consideration is the triggers used to identify the targeted group. Fletcher et al (2004) identified that the triggers chosen were reached as a

consequence of testing the brief questionnaire from two pilot studies. However, there is no evidence in the paper to suggest which particular triggers were chosen or why. The value of this study would have been enhanced if there had been a clear rationale given about the choice of triggers and evidence to support the use of those particular triggers. This would then have enabled readers to consider if this could be generalised for their own practice. Indeed, this view has been corroborated by a paper in the Lancet in 2004 (Stuck, Beck and Egger, 2004) which refutes the validity of the results of Fletcher's study and further raises questions around the most effective approaches to health care for the older population.

Another study carried out in 2002 (Hammond, Iliffe and Elliott, 2002) also considered a targeted approach to the 'over 75' health assessment in terms of identifying vulnerable patients. The initial trigger in this case was patients over the age of 75, registered with one of four practices, who had not seen their GP for two years or more. The numbers were very small and of those, a number were already well known to another member of the primary health care team and therefore not considered for the project. It is interesting to note in this study, that not having seen a GP did not necessarily equate to the need for a health assessment (at least in the opinion of the patients), since a third of those in the target group refused an assessment, perceiving themselves to be in good health. Of those who did receive an assessment however, there was evidence that this was appropriate (Hammond et al, 2002). Unfortunately, this study did not compare the outcomes of assessment for the targeted population with that of the rest and it is therefore inappropriate to assume anything about the vulnerability of those patients who were not assessed. This again raises the question about the validity of the triggers chosen, in relation to the intended outcomes.

In the UK, and only as recently as the last few years, Carpenter declared that, there is currently no evidence base for determining which questions are the most appropriate to use as triggers for determining the presence of wider health and social care problems or vulnerability (Carpenter, 2004). However, the questions for which there is evidence come from the screening research literature.

Validity of self assessment

Targeting assessments for older people has been ongoing in the States and Canada for many years and indeed, the Health Status Form, a self-report screening instrument, has been used since 1985 by health maintenance organisations (HMOs), to predict older people who may be at risk of frailty in the subsequent year (Brody, Johnson and Ried, 1997). Within the American health system, focusing on management strategies and resource delivery on a defined at-risk population is central to efficient medical care delivery, and screening methods are needed to identify those who may be at risk for increased health care needs.

At the time of Brody's study, the Health Status Form comprised an eight-page questionnaire which was sent to HMO members on enrolment and annually thereafter. Although the annual response rate since 1985 had been 92%, this particular study investigated the possibility of reducing the questionnaire to a more manageable number of questions which would readily identify those older people at risk of frailty in the following year. The research yielded thirteen such self-report variables, which were consistent with the literature on functional impairment at the time of nursing home placement in the States (Brody et al, 1997). Unfortunately, the study did not then go on to test the validity of these variables when used in a questionnaire on their

own, but do suggest that the response rate could improve through using a briefer format. Considering the existing high response rate and the fact that health care in the States is not free and it is therefore in the interest of each individual to remain as healthy as possible, it is unlikely that this would be the case.

As early as 1992 in Britain however, Pathy et al (1992), had previously suggested that a two stage approach (screening individuals at risk followed by intervention) may be more efficient than targeting all older people in a given area which, he suggested, may lead to diluting the potential beneficial effect on those individuals at higher risk.

Pathy and colleagues completed a randomised controlled trial with patients over the age of 65 in a general practice in South Wales in which a postal questionnaire was sent at random to eligible patients focusing on functional ability, in an attempt to identify problems (Pathy et al, 1992). Those who received the questionnaire were subsequently followed up by a nurse for verification and intervention. 40% did not identify any problem and were therefore not followed up further. A control group did not receive the questionnaire and had no contact with the nurse. The research lasted three years and identified that the mortality rate in the intervention group was not only significantly lower than in the control group, but also lower than the normal expected mortality rate for people aged over 65 in that particular part of South Wales. This highlights the need for a control group, unlike in Fletcher's study (Fletcher et al, 2004).

The rates for hospital admissions were corroborated by the findings in Fletcher's study, although in the study carried out by Pathy et al (1992), the lengths of stay were

decreased in the intervention group. However, this finding was only significant in the younger age range. The importance of this particular study, albeit small numbers, is in its length, which enabled the researchers to follow patients over a period of time in order to assess the efficacy of interventions on a longer term basis, whilst the control group allowed the researchers to monitor the outcomes of no type of surveillance. Of course, the limitation of this study is that it was based on a single practice only, a point also highlighted by Fletcher (Fletcher et al, 2004).

In 1996, Hébert et al also recognised the value of identifying older people at risk of functional decline. Although Hébert recognised the value of the work completed by Pathy (Hébert et al, 1996; 2001), his research was based on the use of a postal questionnaire proposed by Barber (Barber, Wallis and McKeating, 1981). Hébert tested the validity of this approach by sending a twenty-one item questionnaire to a representative sample of older people living in their own homes in Sherbrooke in Canada. This was followed up a month later with a home visit by a nurse for a full assessment, and a year later, the subjects were reassessed by the same nurse. A stepwise logistic regression analysis showed that out of the twenty one items within the questionnaire, six items could be identified as independent predictors of functional decline (Hébert et al, 1996).

Hébert took this work a stage further in 2001 in order to verify the efficacy of an intervention programme for those people identified through the postal questionnaire. His results were inconclusive with regard to the effectiveness of the interventions as a preventative for functional decline, but did confirm the ability and usefulness of using the Sherbrooke Postal Questionnaire as an initial screening tool to identify those over

the age of 75 who are at risk of functional decline (Hébert, 2001). This method of screening followed by targeted intervention may be viewed as ‘ecological’ in that it can be integrated into an existing system without duplicating services – indeed, has the potential to reduce service needs – and in fact, the six-item questionnaire has been recommended by the Department of Health as a tool which may be used for ‘case finding’ those eligible for SAP (DH, 2002).

A further study by Smeeth et al (2001) compared three different methods of administering a brief screening questionnaire to older people – by post; interview with a lay interviewer; and interview by a nurse – using a randomised comparison of the methods within a cluster randomised trial. This was identified as a research proposal, as although all three methods had been previously tested, no trial had thus far compared the effectiveness of each of these methods with the others. The study design was clearly identified and included areas of possible bias.

The results showed a marked higher response rate for the postal questionnaires as opposed to either of the interview methods in all age groups *except* in the highest age group (90+). No further explanation of this is given in the study. However, it also produced higher proportions of missing or invalid responses and higher prevalence of self reported problems. Smeeth et al (2001) make no clear statement or conclusions identifying that any one method is more effective at screening than others, although they do suggest that the high rate of responses through postal screening, would provide an opportunity to quickly and cost effectively, identify those older people who may be in need of further assessment and/or intervention. The paper also suggests that postal screening would be suitable as a ‘case finding’ method for SAP –

and is an area worthy of further research (Miller et al, 2004).

Perceptions of health

Other research, such as that carried out by Kempen et al (1996), offer a word of caution when anticipating the outcomes of a self-reported questionnaire as a method of case finding those individuals in need of further assessment or intervention. Kempen et al (1996) compared self reporting through a questionnaire, with performance based measures of Activities of Daily Living (ADLs) administered during a home visit. The participants were a subset of those who were part of a larger ongoing longitudinal study (Ormel et al (1992) cited in Kempen et al, 1996). Among the various study findings, it was identified that those participants who had some form of cognitive decline, underestimated functional abilities in a self report, but this was not always borne out in the interview setting.

This finding actually confirmed the results of a number of previous studies (Kelly-Hayes et al, 1992; Sager et al, 1992) and further serves to highlight the need to ensure the appropriateness of the questions if this method is to be used as a screening tool for case finding, since this also has implications for the number of follow up assessments required and therefore, also, the amount of practitioner time. For example, if those individuals with cognitive impairment identify problems with ADLs, which are then not borne out during a follow up assessment, this may be construed as an inefficient use of resources. However, by the same token, it is important that cognitive impairment is recognised at an early stage so that problems may be identified and preventive programmes put in place to avoid deterioration and possible crisis.

The importance of recognising the predictive value of self reporting in terms of future

health needs has been considered by various authors including Grau et al (1998); Benyamini et al (2000) and Lee (2000).

In 1998, Grau et al confirmed the results of earlier works which suggested that although in many cases an older person will perceive their health status to be generally in agreement with assessments made by physicians on the grounds of physical health, a substantial proportion of older people rate their own health as favourable, despite the evidence of co-existing physical illness. It has been suggested that this may be due to an acceptance that with age comes chronic disease (Grau et al, 1998). These findings were explored further in a study by Benyamini et al (2000) which followed elderly residents randomly chosen from a retirement community in America over a five year period, and examined the correlation between self reported health, and functional ability. They identified the importance that self assessed positive indicators of health have on the future health of an individual. Those people who reported that they were in good health, also displayed signs of good physical, social and psychological functioning and were more likely to experience a slower decline in health. This appeared to be true regardless of any concurrent medical condition they may have been experiencing; i.e. positive self assessment of health seemed to be related more to positive physical, social and psychological function, regardless of any co-existing disease processes. These results are further supported by Lee (2000), who followed up a much larger population over a period of six years for functional decline, and seven years in terms of mortality.

Apart from confirming the results identified by Benyamini et al (2000), Lee also identified a number of other predictors. These included the fact that the ability to care

for oneself on a day to day basis was an independent and significant predictor of both functioning and mortality (Lee, 2000). However, a surprise finding was that self care as a predictor of health was different for men and women – for women, this related to functional decline, whereas for men, it indicated a higher mortality risk. This has obvious implications for consideration if such an approach is to be taken in practice.

Methods of self assessment

The literature review thus far has identified the validity of self assessment as a method for screening functional ability in older people and identifying those individuals who would benefit from a more in depth assessment of health and social care needs. In terms of SAP (DH, 2001), this can provide a method of ‘case finding’ those individuals who may require an Overview assessment and may provide a useful tool when considering the obligation for general practice with regard to the ‘over 75’ health check.

However, as we have seen, it is crucial to consider both the method of self assessment and the content of the questionnaire itself.

Various methods of completing a self assessment questionnaire have already been discussed and there is evidence to support postal administration (Hébert et al, 2001; Smeeth et al, 2001; Fletcher et al, 2004). However, as also identified earlier, this method is not without its’ problems (Smeeth et al, 2001). This is supported by Mallinson (1998), who further questioned the effect that respondents’ comprehension of the questions may have on subsequent response rates.

Miller et al (2004) have already confirmed the reliability of the MDS-HC Contact

questions in a self-assessment format for use in general practice, albeit with a very small study population. The MDS-HC assessment tool has a long history of providing quality assessments and has been used in the USA since the 1990s when it was hailed as a major advance in the standardisation of assessment for measuring health care needs and quality outcomes (Carpenter, 2004; Lum, Lin and Kane, 2005). The MDS-HC has also subsequently been recommended by the DH as one of the 'off the shelf' assessment tools for localities to consider using when implementing SAP (DH, 2002).

The producers of MDS-HC further claim that the self-reliance algorithm may be completed as a coarse screening assessment by, for example, a trained receptionist in a GP practice or by telephone (Carpenter, 2004). However, Fries et al (2004) have previously questioned the accuracy of a telephone screening system concluding only that this method could be of 'some' use in screening out the least impaired as well as identifying those for whom a full assessment would be warranted (Fries et al, 2004).

In a more recent paper, Lum and colleagues (2005) evaluated the validity of MDS assessments completed by professionals, in light of research which suggests that data collected in this way is not an accurate reflection of an individual's functional ability (Lum, Lin and Kane, 2005). The study compared the outcomes for completed MDS assessments with interviews with care home residents, their close family and staff members. They discovered that the MDS was more likely to identify fewer ADL difficulties than the interview data when completed by staff, and more difficulties where family or the residents themselves were interviewed. Lum et al suggest the need for direct input from the individual who is being assessed (Lum, Lin and Kane, 2005).

Although this evidence has come to light since completion of the research proposal, it further confirms the appropriateness of self assessment.

Conclusion

The literature reviewed has failed to produce any further evidence supporting a blanket approach to elderly assessment, but rather, supports the notion of targeting specific individuals who display risk factors which may indicate increased vulnerability (Donald and Bulitt, 1998; van Haastregt, 2000). A well researched approach to this is in the form of a self assessment questionnaire used as a screening tool to identify those individuals who require further assessment of their health and social care needs.

The next step in the process is to build on that evidence by investigating the efficacy of using the MDS-HC Contact assessment questions as a postal self-assessment questionnaire in order to screen out those who do not need a full 'over 75' health assessment, and identify those older patients who do require a fuller assessment of their health and social care needs in a general practice population. In this context, screening may be defined as the practice of investigating all 'over 75s' in a practice population, with the object of detecting unmet health or social care needs (or their precursor), in order that measures can be taken that will prevent or delay further deterioration, or improve the situation if there are already such issues (McGarry, 1999).

This however, makes a number of assumptions: -

- that early detection can avert or significantly reduce the health or social care need and improve prognosis;
- the screening procedure itself will, at the very least, do no harm to the individual; and
- there should be savings in terms of health service resources by treating problems before they progress.

It is proposed that this type of case finding approach will reduce the need to see physically well people who have no unmet health or social care needs. In addition it will provide a basis from which decisions can be made about which patients in a practice would derive most benefit from a fuller assessment, thus saving scarce NHS resources.

Chapter Three

Design and Methods

The research question

Does a self-assessment screening tool identify those patients aged 75 and over in a general practice setting who require further assessment of their health needs?

Is this an efficient method for identifying those patients aged 75 and over who require further assessment of their health needs?

Is this form of screening and targeting assessment acceptable to patients in primary care?

What influences how older people perceive their own health needs?

The aims of the study are: -

- To evaluate the validity of a self-assessment screening tool for the selection of patients aged 75 and over, who require further assessment of their health needs.
- To promote older people's health and independence through preventing deterioration and managing crises by targeting assessment and active care management matched to individual circumstances.
- To ascertain the patients' perspective of using this approach.
- To raise the awareness within practices of patients who may be vulnerable or at risk.

- To identify the impact of such an approach on existing practice resources.

The study is based on a survey questionnaire design, although it also displays elements of action research in as much as it is anticipated that the outcomes from the study will not only inform future practice, but also influence change in existing practice (Parahoo, 1997). The study does not meet the criteria for true action research since although there have been changes to practice in the surgeries concerned, the effect of these changes has not yet been evaluated. This differs from conventional research, as the author worked alongside Practice Nurses, who were actively involved in collecting the data for their own practice populations. Two practices were chosen for the study, each presently caring for their elderly population in very different ways, neither of which is thought to be as efficient as it could be and the nurses are keen to see changes which will improve the services they provide. This nullifies the argument made by Meyer in 1993 (Parahoo, 1997), in which a limitation of action research could be a difficulty in addressing the power relationship between the researcher and other collaborators in terms of informed consent, since the nurses involved in this particular study wished to see a change in practice.

Involving the Practice Nurses adds credibility in terms of dissemination of the findings, as they themselves will be empowered through their involvement and will validate the results. However, a weakness of such an approach is that it depends very much on the total commitment of the Practice Nurses to the research, when they have numerous other considerations on their time and workload capacity.

This part of the research is quantitative in nature - only specific, pre-determined data

was collected and analysed and inferences made dependent on the relationships found therein. However, it also portrays elements of a correlational study in that it seeks to find a relationship between the self-assessment questionnaire and a health and social care assessment (Parahoo, 1997).

Targeting the study population

The UK has an ageing population (National Statistics Online, 2004). Although the overall population has grown by 6.5% in the last thirty years or so, the proportion of those aged over 65 has increased (from 13-16%), whereas the proportion under 16, has decreased by 5% over the same period (National Statistics Online, 2004). Continued population ageing is inevitable during the first half of this century, since the number of elderly people will rise as the relatively large numbers of people born after the Second World War and during the 1960s' baby boom, become older. The working age population will also fall in size as the baby boomers move into retirement, as relatively smaller numbers of people have been born since the mid-1970s (National Statistics Online, 2004). Declines in mortality at older ages have contributed to the increase in the number of older people and predictions for 2031 indicate a more rapid ageing of the population over the next thirty years, when people over the age of 85 are likely to comprise 3.8 % of the UK population.

The impact of this within Cheshire West PCT has already been identified, with the population over the age of 75 years in Chester standing at 8.1% of the total population as opposed to 7.6% nationally (National Statistics Online, 2004). Indeed, in mid-2003, 20.4% of the resident population in Chester were of retirement age (65 and over for males or 60 and over for females) compared with 18.5% in England and Wales. In

Cheshire West PCT, the practice population for 'over 75's ranges from 3–10% with an average of 7.8% (Appendix 5).

It has already been acknowledged that there is a wide variation among local practices with regard to the amount of time and importance given to carrying out elderly health assessments (Birnie, 2001). A more recent survey regarding health promotion and health checks for the elderly across the whole of the PCT area, has confirmed that this variation in practice still holds true, even across the rural practices, in which a full elderly assessment template was introduced in 2002 (Cheshire Rural PCG, 2002; Miller et al, 2004).

Therefore, in order to choose a sample population which would reflect the widest range of responses and enable the outcomes to be generalised to the rest of the practices within the PCT, it was decided to approach two practices, one each at either end of the spectrum, in terms of their existing approach to the 'over 75' health check. However, both were not only similar in their practice populations in terms of size and demography, but also had population profiles typical to the area.

Characteristics of study population

- Both practices have a history of participating in innovative and new ways of working;
- Both have amongst their patients, those from the most deprived wards in the area, as well as the more affluent;
- Practice A does not presently offer any health checks for their elderly population;

- Practice B is in the fortunate position of having a Practice Nurse who is dedicated to the care of the ‘over 75s’ and who sees everybody within that range at least annually for a full assessment.

Table 1: Practice population profiles

	Practice Population	Over 75 Population	% population over 75 years
Practice A	10921	907	8.3
Practice B	10791	696	6.5

The Practice Nurse from Practice B reported that a number of those patients she saw were quite independent and did not actually require a full assessment. The use of a self-assessment screening tool to identify those who do not require further assessment should enable her to utilise her time and skills more efficiently for those patients who do require further intervention.

Practice A had recently decided they needed to take a more proactive approach in caring for their elderly population and had recently requested the help of the author in developing protocols for reviewing their elderly patients, in line with the targets in the NSF for Older People. This had been initiated, not only because of the NSF, but also due to the fact that there had been a number of incidents in which a GP had been requested to visit older patients whom they knew very little about, only to arrive in the middle of an acute crisis. This then necessitated intensive and time consuming interventions and referrals, which they recognised could have been avoided, if they had prior knowledge of a deteriorating situation.

This is supported by McIntosh, Young and Stewart (1988), in a project which converted an on-demand, crisis intervention service, similar to Practice A, into a

doctor-initiated, anticipatory and preventive programme, to improve management based on home visiting and Activities of Daily Living screening by a State Enrolled Nurse, with serial medical assessment and surveillance by a GP. The ability or inability to perform ADLs can be used as a very practical measure of ability/disability in many disorders. Over time, this enabled identification of high need/risk patients and enabled the practice to become more focused and targeted in their approach. However, this particular approach increased the total practice workload by 9% per annum, although patient initiated calls fell by 41%. From Practice A's point of view, it was felt that the research project may offer an acceptable compromise and would support both practices in terms of not just in informing their individual practice development, but also informing future assessment and health promotion for the 'over 75' population in general practice across Cheshire West PCT.

A number of meetings took place, which included a Practice Nurse from each practice, the author and a Research and Development (R&D) officer, to ascertain the best way of taking the research forward. Follow up meetings occurred on a regular basis throughout the study period to review progress and discuss any issues which arose as a result of the methods used. It was recognised that the time required from the Practice Nurses, who would be carrying out the data collection, would be extra to their normal duties. This was calculated at four hours per week and it was agreed that the costs would be met by research funding available through the PCT. Both nurses were aware of their obligations under the Data Protection Act (1998), and were working within their professional Code of Conduct (ICN, 1996; NMC 2002).

Process – quantitative study

In order to satisfy the research question therefore, a social survey comparative design approach was used, comprising a cohort study in which a sample of the ‘over 75’ year old population from the two GP practices was used to compare the outcomes of a self-assessment questionnaire with a face to face health and social care assessment.

A stratified random sample of the population was taken, targeting individuals who reached their 75th, 85th and 95th birthday during the year of the study (Bryman, 2001). Using this sampling method identified enough numbers to represent the ‘over 75’ population in each practice and thus allow sufficient power to enable appropriate analyses to be made, therefore ensuring that generalisations can be made to other practices across the health economy.

Participants were selected according to their birth date – all patients who were born in 1908, 1918 and 1928, were invited to take part in the research project. This raised a sample of 203 patients across the two surgeries.

Table 2: Sample size for each practice

	75s	85s	95s	TOTAL
Practice A	81	25	8	114
Practice B	59	26	4	89
TOTAL	140	51	12	203

A self-assessment questionnaire, which mirrored the one used in the county project in 2001, was sent from the practice to each participant who was given one month to complete and return the questionnaire. Each participant also received an information leaflet and consent form (Appendix 6).

The answers from the questionnaire were collated according to the analysis used in the project in 2001 in order to assess whether the participant was ‘self-reliant’ or ‘not self-reliant’ according to the way in which the questionnaire was answered (Appendix 7).

The analysis comprised: -

1. Self-assessment questionnaire received **complete** and identified as ‘self-reliant’ (not requiring further assessment) or ‘not self-reliant’ (in need of further assessment/intervention) according to the protocol.
2. Self-assessment questionnaire received **incomplete** – this was taken to indicate a state of ‘not self-reliant’ for the purpose of the research project.
3. Self-assessment questionnaire **not returned** – this was taken to indicate a state of ‘not self-reliant’ for the purpose of the study.

A further protocol was defined for the purpose of the research and assumptions made which could be verified through a follow up assessment (Appendix 8).

The participant was then invited to either attend the surgery for the follow up assessment, which included all the domains as outlined in the overview assessment of SAP, or visited in their own home, residential or nursing home.

The follow up assessment, comprising the ‘overview’ assessment criteria as indicated earlier (Appendix 4) was then completed with all participants.

The outcome of the ‘overview’ assessment was considered with the results of the initial questionnaire for each participant, in order to evaluate the validity of the self-assessment screening tool for selecting patients who require further assessment of their health needs and to ascertain the appropriateness of the assumptions made.

This is summed up in Table 3.

Table 3: Process of analysis

Questionnaire	Assumption	Outcome on assessment
Complete	Self reliant *	Assumption correct/ assumption incorrect
	Not self reliant *	Assumption correct/ assumption incorrect
Incomplete	Not self reliant	Assumption correct/ assumption incorrect
Not returned	Not self reliant	Assumption correct/ assumption incorrect

* According to analysis of questions

Any further investigations or referrals that arose as a result of this assessment were also completed.

Process – qualitative study

In order to inform the feasibility of promoting the course of action suggested across the health economy, regardless of the outcomes of the main study, a small qualitative study ran alongside the main project, which explored participants’ perceptions of the questionnaire/screening process. A random selection of participants, stratified from each age group, considered aspects of the main project from the participant’s perspective. The follow-up study took the form of individual, face-to-face, semi-structured interviews with a small number of participants from each age group, who had previously taken part in the main study (Appendix 9).

According to Parahoo (1997) an interview can be described as

“... a verbal interaction between one or more researchers and one or more respondents for the purpose of collecting valid and reliable data to answer particular research questions.” (Parahoo, 1997, p. 282).

In this instance, the data gathered were the views of the participant on the process of using a self-assessment questionnaire as a screening tool for making the decision on whether or not to complete a more in-depth health and social care assessment of their needs.

The outcomes from the interviews were analysed using the ‘grounded theory’ or constant comparative method: - all the interviews were transcribed verbatim and categorised into a number of themes (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Parahoo, 1997).

These themes were explored and the answers coded, in order to inform future processes. They included:-

- Participant understanding of the self-assessment questions;
- Participant perception of the use of the self-assessment questions;
- Participant perception of the overall aims of the project;
- The impact of the self-assessment questions on the participant in terms of positive or negative views toward having a full health assessment;
- How the participants viewed their own health.

Taken from a phenomenological viewpoint, in order to focus on the individuals’ interpretation of their experience, this part of the study set out to ascertain whether the participants’ view of the benefits of the process in the main study matched that of the

author.

The outcome of these interviews should inform the feasibility of promoting such a course of action across the health economy, whatever the outcomes from the main study. In other words, in order for the follow-up study to be credible, the purpose of the interviews was to collect data to satisfy the author's curiosity, and, if the findings are to be valid, to use this to support or negate the findings from the main study.

An individual interview technique was chosen in this instance rather than a focus group as much of the discussion centred on how participants view their own health and their expectations of the health services they receive. This can be quite personal and face-to-face interviewing can be considered as threatening. It was therefore important that participants volunteered to be interviewed and that confidentiality and anonymity were maintained.

An information sheet, covering letter and consent form were given to each subject prior to participation. Face-to-face interviews are time consuming and therefore only a small number of participants were used. The use of individual interviews avoids the possibility of having personal views influenced by other participants. Conversely however, individual interviews also have the ability to adversely influence outcomes. However, it enables a researcher to obtain a rich source of qualitative data and allows for more in depth exploration than a written questionnaire may allow. In order to avoid this therefore, it was important that the interviewer was seen as a neutral party – perhaps a different person to the one who carried out the assessments in the main study and who was already known to the participants (Parahoo, 1997).

Although, ostensibly a qualitative study in view of the fact that it included collecting individual views and not specific data, the interviews themselves were semi-structured, thus adding in an element of quantitative research.

In semi-structured interviews, respondents are all asked the same questions, although there is some flexibility in the phrasing and ordering of the questions, in order to enable respondents to be helped to understand the questions and also allow the interviewer to seek clarification on the responses. Although the use of a semi-structured interview technique allows some flexibility to probe, this is limited to seeking clarification and obtaining more complete answers, rather than uncovering new perspectives. This approach allows comparisons between respondents to be made, which is a very useful technique in the study of sensitive topics such as one's own health. The validity of this approach is enhanced by the presence of the interviewer who can clarify the questions and seek clarification from the respondents. The use of a tape recorder and transcription further helps to avoid any ambiguity or bias (Parahoo, 1997).

Limitations

- As previously identified, the Practice Nurse in Practice B, was used to seeing all patients over the age of 75 on an annual basis and in this way, her participation in the project had little influence on her daily workload, apart from the additional responsibilities of sending out and receiving the questionnaires prior to the overview assessment. The majority of older patients in the practice were used to receiving invitations to attend the practice for assessments so there was little disruption to normal practice.

- The situation in Practice A was very different since there was no history of seeing older patients on a regular basis. In this case, the Practice Nurse had to find the time within her busy working day to accommodate the extra workload entailed within the project. In order to support her with this, a Health Care Assistant was recruited to attend to the sending out and follow up of questionnaires. This helped to speed up the process, but Practice A took longer to complete the data collection than Practice B.
- The photocopying of letters and administration time required to send out, follow up and quantify the replies took longer than anticipated for both practices and is a factor which needs to be taken into consideration when staff time is being utilised.
- Including a stamped, addressed envelope for returning the questionnaires was a useful addition for encouraging participants to reply to the information requested through the study. For the purposes of the project, the cost of stamps was reimbursed through the PCT R&D Department.
- The costs of photocopying were absorbed by each practice for the duration of the study, since the numbers required were relatively small. Once again, this would have more severe cost implications if all the 'over 75' practice population were included.
- It was found that existing workload on the part of the researcher, availability of a suitable venue, and the willingness of participants to take part in a face-to-face interview, led to a delay in completion of some of the interviews and in some instances, there was a period of up to a month between the follow up assessment and the interview taking place. For a minority of participants this meant that they had forgotten the reasoning behind the original questionnaire

and also a number of the questions. Gentle reminders were generally sufficient to jog their memory, although this was identified as a limitation to the outcomes of the qualitative study.

Ethical considerations

The proposal was constructed, and ethical approval sought through the South Cheshire Ethics Committee.

Apart from local research ethics committee approval, the study was also subject to independent peer review and the local PCT clinical governance approval and agreement process. In order to achieve approval, all projects must prove their relevance to the PCT including approval from the PCT's Caldecott Guardian (DH, 1997). The proposal was also supported by two independent reviewers for its scientific merit and approved by the PCT Clinical Governance Service Delivery Group.

Support for, and consent to allow the research to take place, was also sought from the GPs within each practice, who received full information on the proposal (Appendix 10), (Data Protection Act, 1998).

Informed consent

The primary function of informed consent is protecting and enabling autonomous choice (Beauchamp and Childress, 2001). Rational decisions can only be made if sufficient information about what participation entails and any associated risks or consequences is given to potential participants. This means that research participants

must be informed about the nature of the research and that participation should be voluntary without any consequences for non-participation (Gelling, 1999). Consent should be secured, preferably in writing, in language that the participant can understand (DH, 2001a). In this study, an invitation letter was sent to all prospective participants, accompanied by an information sheet and consent form (Appendix 6).

Participation in the study was on a voluntary basis and patients were assured that if they did not wish to participate, there would be no consequences. Participants were also able to withdraw from the study at any time, without having to give a reason and assured that there would be no consequence in doing so.

Confidentiality and anonymity

All participants were assured of anonymity. This was guaranteed by making the identity of the participants anonymous. Those participants who took part in the follow up interviews were also assured of anonymity. All data was stored in compliance with the Data Protection Act, 1998. Audiotapes and transcripts were also destroyed in compliance with the Data Protection Act, 1998. The researcher had no access to the identity of participants.

Identity of researcher

All data collected within the study, apart from the face-to-face interviews, was collected by the respective Practice Nurse from each surgery. Although these nurses were known to many of the participants, the data collected in the main part of the study was largely quantitative in nature, which would minimise the effect of any bias. With regards to the interviews, these were carried out by the researcher who was

unknown to the participants.

Conclusion

The project ran for a period of one year from June 2003 to June 2004.

Chapter Four

Results

Introduction

A total of 203 questionnaires were sent out.

167 (83%) participants completed the main part of the study, with Practice A achieving a 74% (84/114) completion rate and Practice B achieving 93% (84/89).

The results show that a self assessment screening tool is a valid means for identifying individuals who required further assessment of their needs in 154 of the 167 participants (92%) who completed the study.

Table 4: Overall results by age breakdown of all participants

	75s	85s	95s	TOTAL
Participants for whom the self-assessment questionnaire analysis was appropriate	114 (93%)	34 (89%)	6 (100%)	154 (92%)
Participants for whom the self-assessment questionnaire analysis was inappropriate	9 (7%)	4 (11%)	0	13 (8%)
TOTAL	123	38	6	167

Fourteen participants were interviewed for the follow up qualitative study. All were happy to complete the questionnaire although two were unsure about the possibility of not having a fuller assessment.

Participation

Table 5 shows the age breakdown by practice of participants. Non-completion of the study comprised those who did not attend for the follow up assessment.

Table 5: Total number of participants in study by practice

	Practice A			Practice B		
	75s	85s	95s	75s	85s	95s
Questionnaires sent out	81	25	8	59	26	4
Participants completing study	66 (82%)	14 (56%)	4 (50%)	57 (96%)	24 (92%)	3 (75%)

The reasons for non-participation is summarised in Appendix 11.

Response to questionnaires

The responses to the questionnaires are shown in *Table 6*.

Table 6: Response to questionnaires

	75s	85s	95s
Questionnaires returned complete	112 (80%)	35 (69%)	8 (67%)
Questionnaires returned incomplete	1 (1%)	0	0
Questionnaires not returned	27 (19%)	16 (31%)	4 (33%)
TOTAL = 203	140	51	12

This is broken down for each practice in *Table 7*.

Table 7: Breakdown of response to questionnaires by practice

	Practice A			Practice B		
	75s	85s	95s	75s	85s	95s
Questionnaires returned complete	67	17	5	45	18	3
Questionnaires returned incomplete	0	0	0	1	0	0
Questionnaires not returned	14	8	3	13	8	1
TOTAL	81	25	8	59	26	4

From the total number of participants, 131/168 (78%) were self reliant and did not require a full assessment of their health/social care needs. This is reflected for each practice in *Table 8*.

Table 8: Participants who were self reliant

	Practice A	Practice B	Total
Number of participants identified as 'self reliant'	64 (76%)	67 (80%)	130 (78%)
Number of participants identified as 'not self reliant'	20 (24%)	17 (20%)	37 (22%)
Total number of participants	84 (100%)	83 (100%)	167 (100%)

Validity of questionnaire

Table 9 sums up the validity of the questionnaire in relation to the original assumptions made.

Table 9: Outcome of assessment in relation to analysis of questionnaire

Questionnaire	Assumption	Outcome on assessment		
		Assumption correct	Assumption incorrect	Outcome not known (non participant)
Complete	Self reliant	122 / 136 (90%)	4 / 136 (3%)	10 / 136 (7%)
	Not self reliant	16 / 19 (84%)	0	3 / 19 (6%)
Incomplete	Not self reliant	1 / 1 (100%)	0 / 1	0 / 1
Not returned	Not self reliant	15 / 47 (32%)	9 / 47 (19%)	23 / 47 (59%)
TOTAL (203)		154	13	36

The breakdown by age, for those participants for whom the assumption was appropriate, is depicted in Table 10.

Table 10: Participants for whom analysis was appropriate

	75s	85s	95s
Participants for whom analysis appropriate	114	34	6
Of the participants for whom analysis appropriate, numbers identified as 'self reliant'	95 (83%)	24 (70%)	3 (50%)
Of the participants for whom analysis appropriate, numbers identified as 'not self reliant'	19 (17%)	10 (30%)	3 (50%)

Completed questionnaires

155 questionnaires were returned complete – 76% of the initial number of questionnaires.

Table 11 shows the analysis made in relation to the responses from the completed questionnaires.

Table 11: Analysis for completed questionnaires

	75s	85s	95s
Participants identified as 'self reliant'	101	31	4
Participants identified as 'not self reliant'	11	4	4
TOTAL	112	35	8

This is illustrated for each practice in Table 12.

Table 12: Analysis for completed questionnaires by practice

	COMPLETED QUESTIONNAIRES ONLY					
	Practice A			Practice B		
	75s	85s	95s	75s	85s	95s
Participants identified as 'self reliant'	56	16	2	45	15	2
Participants identified as 'not self reliant'	11	1	3	0	3	1
TOTAL	67	17	5	45	18	3

Appendix 12 outlines the reasons given for participants identified as 'self reliant' but who did not attend for the follow up assessment.

Table 13 depicts the ability of completed questionnaires to identify individuals who require further assessment.

Table 13: Results for completed questionnaires

	75s	85s	95s
Participants for whom the self-assessment questionnaire analysis was appropriate	104 (93%)	28 (80%)	6 (75%)
Participants for whom the self-assessment questionnaire analysis was inappropriate	3 (3%)	1 (3%)	0
Number of participants who did not attend follow up assessment	5 (4%)	6 (17%)	2 (25%)
TOTAL	112 (100%)	35 (100%)	8 (100%)

This is further broken down in relation to the appropriateness of the questionnaire in relation to analysis of ‘self reliance’ and ‘not self reliant’.

Table 14: Breakdown of appropriateness of questionnaire in relation to analysis of ‘self reliance’ and ‘not self reliant’

	75s	85s	95s
Participants identified as ‘self reliant’	101	31	4
Participants for whom the self-assessment questionnaire analysis was appropriate	95 (94%)	24 (77%)	3 (75%)
Participants for whom the self-assessment questionnaire analysis was inappropriate	3	1	0
Number of participants who did not attend follow up assessment	3	6	1
Participants identified as ‘ not self reliant’	11	4	4
Participants for whom the self-assessment questionnaire analysis was appropriate	9 (82%)	4 (100%)	3 (75%)
Participants for whom the self-assessment questionnaire analysis was inappropriate	0	0	0
Number of participants who did not attend follow up assessment	2	0	1

Unreturned questionnaires

47 questionnaires were not returned – 23% (47/203) of the total number of questionnaires.

25 of these went on to have a follow up assessment and complete the study.

The analysis assumption for unreturned questionnaires indicated ‘not self reliant’ and in need of further assessment/intervention. The outcomes were very different.

Table 15 reflects the actual results.

Table 15: Results for unreturned questionnaires

	75s	85s	95s
Participants for whom analysis was appropriate	9 (33%)	6 (38%)	1 (25%)
Participants for whom the analysis was inappropriate	6 (22%)	3 (19%)	0
Number of participants who did not attend follow up assessment	12 (45%)	7 (43%)	3 (75%)
TOTAL	27 (100%)	16 (100%)	4 (100%)

The reasons for not returning the questionnaire, yet subsequently attending for the follow up assessment are summed up in Appendix 13.

Qualitative study

Fourteen interviews were completed.

Receiving the questionnaire

Only one (Interview 4), was slightly concerned about completing the questionnaire, but did so anyway. Their concern centred on the fact that they wished to clarify the answers they gave, which they did by completing the free text boxes.

Four of the interviewees did not understand why they had received the questionnaire, although were happy to complete it when they realised it was from the surgery.

Only three interviewees referred specifically to the research project although the other seven were able to identify that it was to do with looking after the needs of older people (Appendix 14).

Understanding the questions

All interviewees found the questions easy to understand although in one case (Interview 3) they were answered by the interviewee's daughter in collaboration with the interviewee.

None of the interviewees found any of the questions to be upsetting or offensive.

Purpose of the questionnaire

One interviewee (Interview 11) did not understand the purpose of the questionnaire, although they had answered all the questions without difficulty.

One interviewee (Interview 9) could not remember why they had been sent the questionnaire (Appendix 14).

Twelve of the interviewees felt they understood the reasons for the questionnaire – it was some way related to the practice supporting them to keep healthy (Appendix 14).

All the interviewees stated that they were happy to complete the questionnaire as they were fully aware that it came from their own GP surgery. All were content with the services they received.

Perception of process

The interviewer explored how the interviewees had felt about the process (questionnaire followed by assessment) and asked their views on how they would feel if they received the questionnaire only, without the follow up assessment.

Eleven interviewees were quite happy to complete the questionnaire without

necessarily having a follow up assessment, although two (Interviews 6 and 7) identified that they would like to feel they could contact the surgery at any time if they had any concerns.

Two specifically stated that they would automatically make an appointment to see their GP if they felt that was necessary (Interviews 7 and 13).

Of the three who would not be happy without a follow up assessment, one (Interview 3) stated that she would feel 'let down' if nobody visited her at home (85 year old, Practice B).

Both the others (Interview 10 and 11) felt that the follow up assessment would be reassurance for them that all their needs were being met (Appendix 14).

Perception of health

This area explored how the interviewees viewed their own health and well being; what, if any, steps they made to improving their health, and if there were any constraints preventing them from achieving their own personal health goals.

Thirteen interviewees felt that their existing health status was commensurate with their age and they all had expectations that there would be a decline in health status with advancing age.

Two interviewees (Interviews 8 and 9) commented particularly on problems with their legs which had caused decreasing mobility and therefore, ability to be independent.

When asked about steps made to improve existing health status, one interviewee (Interview 12) asked for the recorder to be switched off to discuss an alternative therapy which was being used to increase his health.

One other (Interview 4) had recently given up smoking, and a third (Interview 1) felt that the only way to improve his health would be to 'win the lottery'.

When exploring barriers to achieving health goals, twelve interviewees felt that they were already achieving the best health status they could.

Two interviewees identified specific barriers to achieving their own health goals - the length of hospital waiting lists (Interview 7) and continual leg pain which was not relieved, even with analgesia (Interview 3).

Conclusion

The results illustrate that a self assessment screening tool is a valid and acceptable means for identifying individuals who require further assessment of their needs in the majority of patients aged 75 and over in the population studied.

Chapter Five

Discussion and Recommendations

Introduction

The results of the study suggest that a self-assessment questionnaire is a valid and useful means of selecting those patients aged 75 and over in two general practices, who require further assessment of their health needs. The findings are most reliable when the questionnaires are returned complete – being valid in 75% of cases for 90 year olds and 94% for 75 year olds.

The number of questionnaires returned complete was a higher than expected response rate for a postal questionnaire – an average of 72% (Smeeth et al, 2001). This may have been due to the fact that it was a research project and it remains to be seen if this continues should the process be rolled out.

23% (47/203) of questionnaires were not returned. The analysis assumption for unreturned questionnaires indicated 'not self reliant' and in need of further assessment/intervention. In fact, the outcomes were very different. This analysis was appropriate in an average of only 32% of cases although the percentage of non-attenders at the follow up assessment ranged from 43 in the lower age groups, to 75% in the 95 year olds.

Discussion – main study

Stuck et al (2004) claim that successful prevention of disability in older people requires an approach which is tailored to the needs of different groups. Their results

support the present study in suggesting that targeting is likely to be most effective in the younger age group, whereas the older age groups would benefit from a more universal and comprehensive assessment. The results outlined here also concur with the outcomes of the study by Smeeth et al (2004) in which the response rate for postal questionnaires declined with increasing age. In the author's own study, the response rate for return of questionnaires was 81% for 75 year olds and had dropped to 67% for 95 year olds.

It is suggested that the reason for the greater uptake in numbers participating in the study in Practice B (average 88%), as opposed to Practice A (average 63%), is due to the fact that Practice B has a culture of seeing every patient at 75 years and over on an annual basis and that there is therefore an expectation that there will be communication from the practice regarding health issues at this age. The reasons for inability to participate in the study are given in Appendix 11. In both cases, the Practice Nurse completing the data collection contacted all those to whom questionnaires had been sent after the one month reply date had elapsed. The low response rate in the 95 year age group may reflect a general frailty in this group.

Table 9 sums up the outcomes of the follow up assessment in relation to the original analysis from the self-assessment questionnaire. This confirms that some assumptions about the health status of an individual can be made dependent on the answers produced within a completed questionnaire. If a questionnaire identified a participant to be 'self reliant', this was true in 90% (122/136) of cases. On the other hand, if a questionnaire identified that a participant was 'not self reliant', this was also valid in 84% (16/19) cases.

The assumptions identified in the original protocol (*Table 3*; Appendix 8) proved to be most reliable in the younger age group and became less reliable in the highest age group – 93% (114/123) appropriate at 75; 89% (34/38) at 85; and 50% (6/12) at 95. However, the greatest percentage of participants who were also identified as ‘not self reliant’ and therefore requiring further assessment and intervention, also fell in to the highest age group (50% at 95 as opposed to 17% at 75 years) and it is suggested that for the small number of patients this entails, a self assessment questionnaire as a screening tool is perhaps not as appropriate at this age as would be a full holistic assessment (Stuck et al, 2004).

Completed questionnaires

If returned complete, it would appear that the self-assessment questionnaire is a valid means of identifying those older people in two general practice populations who require further assessment of their health and social care needs (*Table 13*).

76% (155/203) of the original number of questionnaires were returned complete. As has been identified previously, this correlates well with the evidence for postal questionnaires.

In 94% (104/112) of 75 year olds, a completed questionnaire provided an accurate guide as to whether further assessment was required. In this age group, the completed questionnaire produced an inaccurate guide in only 3% (3/112), all of whom identified as ‘self reliant’ but on assessment were ‘not self reliant’. Carpenter (2004) has previously confirmed that where the MDS-HC contact assessment has identified patients to be self reliant, for >5% this will not be the case.

Unfortunately, a number of participants in the higher age groups, who completed questionnaires, did not subsequently attend for the follow up assessment – 17% (6/35) of 85 years olds and 25% (2/8) of 95 year olds. Since no data is available for these individuals, no further assumptions can be made with regard to the validity or otherwise of their questionnaires.

Incomplete/Unreturned questionnaires

According to the original assumptions (*Table 3*), participants who returned incomplete questionnaires or did not return them at all, were assumed to be ‘not self reliant’ and in need of further assessment.

In the study by Smeeth et al (2001), although the postal questionnaire had the highest response rate, it also produced higher proportions of missing or invalid responses and higher prevalence of self reported problems. In the author’s study however, only one of the returned questionnaires was incomplete. This was a participant at Practice B, who, at follow up assessment was found to be ‘not self reliant’ and therefore, in this single case, the assumption was correct. However, the fact that this was the only incomplete questionnaire in the whole study seems to indicate that this would not be a common occurrence. No further conclusions can be drawn from such a small sample.

As previously noted, the vast majority of those who did not return their questionnaire (30) and subsequently did not attend for assessment (i.e. did not participate in the study), were from Practice A, the reasons for which have been identified in Appendix

23% (47/203) of questionnaires were not returned. The analysis assumption for unreturned questionnaires indicated 'not self reliant' and in need of further assessment. Twenty five of those who did not return their questionnaire (53%) went on to have a follow up assessment and complete the study. The analysis assumption was appropriate in less than 40% (25%-38%) of this group.

An unreturned questionnaire is therefore, not necessarily an indication that an individual is in need of further assessment – no conclusions of this sort can be drawn from the sample used in this study. Although half of those (25/47) who did not return their questionnaires did receive a follow up assessment, there was a significant number who did not. This has implications for use of resources in practice, since an unreturned questionnaire would need to be followed up, but there still may be refusal or reluctance to have a full health assessment. This relates back to initial discussions in which it was highlighted that those people who did not accept invitations for an 'over 75' health check, missed out although there may be little evidence of level of need amongst this population (Hammond et al 2002).

Non Participants

18% (36/203) of those originally sent questionnaires did not participate in the study. The percentage of non-participants increased with age in both practices, although this was most marked in Practice A (*Table 5*). A possible explanation for the lack of participation in the 95 year age group could be due to extreme age and the frailty which comes with that. A number of these individuals were also living in nursing homes. This supports the findings of Smeeth et al (2001) whose results for a postal questionnaire showed a high response rate in all age groups except the highest age

group (90+). This raises the question as before, as to whether these should be the individuals who are targeted for full assessment without the need for an initial self assessment.

Self Reliant

The vast majority of participants, 131/167 (78%), were 'self reliant' (*Table 9*). The results are more reliable in the younger age groups for those participants identified as 'self reliant' according to the questionnaire and for whom this was subsequently found to be the case - 50% (3/6) at 95; 70% (24/34) at 80; and 83% (95/114) at 75 years. The assumption of 'self reliance' was incorrect for only 3% of participants.

In addition, it must not be forgotten that a percentage of unreturned questionnaires also related to individuals who were subsequently also found to be 'self reliant'. From the practice point of view, this should go some way to enable them to plan their time and resources accordingly. For Practice B, this has implications for releasing some time which is presently spent by the Practice Nurse performing full assessments on all the over 75 year old population, to do other things. For Practice A, this gives an indication of the amount of time and resource which is likely to be required to properly target and assess their elderly population.

Not Self Reliant

Of those participants who identified self reported problems, the self assessment was appropriate in 82–100% of cases (except in the 95 year olds). This work is corroborated to some extent by the study by Kempen et al (1996). Among the various study findings, it was suggested that those participants who had some form of

cognitive decline, would underestimate their own functional abilities in a self report, but that this was not always borne out in the interview setting. In some respects, as far as the author's study is concerned, this may actually prove to be a useful finding, since a self reported reduction in functional ability would automatically create the need for further assessment, which would then identify any areas of cognitive decline. The opposite is also true, since the first question in the self-assessment questionnaire refers to cognitive function and any reduction in cognitive ability would automatically create the need for further assessment, which would then also identify areas of functional decline.

Variances

Three participants completed their questionnaire and were identified as '**not self reliant**' but did not attend for their follow up assessment (*Table 14*). The reasons given were: -

- The questionnaire had been completed by the daughter of the 95 year old participant who was living in a nursing home and was unable to give their own consent due to frailty – a further assessment in this case is likely to have been appropriate.
- Of the two 75 year olds, one moved out of the area in the interim between returning the questionnaire and the follow up interview date; and the other was admitted to hospital during the study with a stroke.

For those participants (4) identified as '**self reliant**' but for whom the questionnaire was **inappropriate** (*Table 14*), the reasons identified included: -

- In two cases the questionnaire was completed by the participant's daughter who was the main carer.
- One of the 75 year olds answered the questions inappropriately on purpose as he had not seen a health professional in some time and feared that he was ill but did not wish to admit this. At the follow up assessment, further investigations revealed that he was suffering from cancer and in actual fact, died soon after.
- One participant had answered all the questions as if he managed on his own but in fact depended on his wife for cooking, housework and bathing.

Discussion - follow up study

It was envisaged that there would be a total of twenty interviews (ten per practice). Unfortunately this proved difficult due to workload pressures and therefore only fourteen interviews were completed, comprising a mixed age range and level of health across the two practices. Efforts were made to ensure that this sample remained stratified across the age groups.

There was also at least one interviewee for which the questionnaire had not been returned.

Although each interview followed the same schedule (Appendix 9), there were variations in the ways the answers were expressed since the language used by the interviewer was modified to be culturally sensitive dependent on the age, gender and understanding of terminology of participants. The time lapse between the follow up assessment and the interview varied between a few days and a few months and

therefore, in some cases, interviewees were unable to remember all the details of the research project.

It is pertinent to note however, that in all cases, the interviewees commented on how satisfied they were with the services they were presently receiving from their GP practice, and all had confidence that they were receiving the best of care.

Although only a very small sample of the original study population were followed up by interview, it is possible to glean a flavour of how such an approach may be perceived by older people in a practice population. The main themes that have emerged from the interviews can be amalgamated under three headings: - feelings; understanding and perception.

A number of participants were unsure of why they had been sent the questionnaire, but once they realised it had been sent from the GP practice, were more than happy to complete it. Neither did they all understand the reasons behind the particular questions. The predominant perception was that the practice was 'checking up' on them, which gave participants a feeling of security. This brings into question how older people perceive their GP and the health service in general, i.e. authority; knowledge; confidence; raising further food for thought and a possible project for further research.

In terms of how participants felt about completing a questionnaire without the follow up assessment, only three said they would feel 'let down', whilst the other nine felt confident enough to accept the decision as they knew they could contact the practice

themselves whenever they required. It is pertinent to note that those participants who said they would feel 'let down', were also participants whom the questionnaire had identified as 'not self-reliant', and who were presently quite dependent on the practice for on going needs.

All participants found the questionnaire easy to complete and understood the questions. When asked about their own perceptions with regard to their present health status, the majority feeling was that whatever their health status at the time, it was only what was to be expected considering their age.

This poses the question about individual health perceptions, why it is that an individual's health status, which may differ vastly from their neighbour, is an accepted part of getting older. The range of health status from fit and healthy, to very dependent is accepted as a consequence of increasing years. This relates to a study carried out in Japan by Matsubayashi et al (1997), where it had been accepted practice since 1992, that all older people over the age of 65 years received a quality of life questionnaire, which included subjective healthiness and life satisfaction self-reporting. It is interesting to note, that whilst the proportion of independent older people greatly increased from 1992 to 1997, the study showed that scores of both subjective healthiness and life satisfaction, did not change (Matsubayashi et al, 1997). In order to explore why some older people have expectations that poorer health comes with increasing age requires an understanding of the broad range of influences on people's health.

This may be explained to some extent by Dahlgren and Whitehead's (1991) model for

the main determinants of health (Appendix 15). This can be further illustrated through the research reported by Grau et al (1998) and Benyamini et al (2000), which highlight the importance that self assessed positive indicators of health have on the future health of an individual. Those people who display signs of good physical and social functioning and a positive attitude were more likely to experience slower decline in health, and regardless of whether they experienced such declines over the years, were more likely to preserve favourable assessments of their own health, compared with less happy or energetic people (Benyamini et al, 2000).

A mass of evidence has accumulated since the publication of the Black Report in 1980 (Townsend et al 1988) relating to variations in health status according to socio-economic factors, unemployment, housing and homelessness, gender, culture ethnicity and age. The connections between socio-economic status with accumulated advantages/disadvantages through the life course and their effect on health, is further supported by the Health Belief Model adapted from Becker and Rosenstock (Becker and Rosenstock, 1984; Champion, 1984), (Appendix 16). These models emphasise interactions between the different factors – it is interesting to note that those participants who were interviewed and who felt comfortable with their health status were also confident that they could seek and receive adequate health support as and when required. On the other hand, those who felt they needed to also have a follow up face-to-face assessment, were the same people who felt less well and were not coping well with their state of health. This variation in perception was not restricted to either one practice or the other.

Recommendations for practice

- Continue with rollout of the project to all 'over 75' year olds in the two practices, in order to produce further evidence about the validity of such an approach.
- Pilot the same process with other interested practices across the PCT in order to validate the results from the original study.
- Pilot the use of the self-assessment questionnaire on an annual basis as a crude screening tool, in conjunction with existing knowledge of individuals, as outlined in Appendix 17.
- Protocols for the follow up of unreturned questionnaires will require discussion within the primary health care team as to their agreed approach. This may include consideration of other factors already known to the team.
- Due to the unreliability of the self-assessment questionnaire in the highest age group and their likely general frailty, it is suggested that this group will require individual face to face assessments.

Chapter Six

Conclusion

This project set out to investigate the utility of a self assessment questionnaire as a screening tool for targeting those patients over the age of 75 years requiring further assessment of health/social care needs. It is envisaged that the outcomes from the project will inform future assessment and health promotion for the 'over 75' population in general practice across Cheshire West PCT, in line with the guidance around SAP and also enable practices to develop a profile of their vulnerable elderly.

This research project has shown that the use of a self-assessment questionnaire is a valid means of identifying those patients over the age of 75 years in two GP practices, who require further assessment and/or intervention. The results are most conclusive when the questionnaire is returned complete; however, if a questionnaire is not returned, this may be for a variety of reasons and therefore, requires follow up.

This project has also identified the appropriateness of the questionnaire to be used in a postal self-assessment format which is acceptable to the majority of patients in the study population. It further appears that in the majority of cases, at the age of 75 years, most people are still fit and healthy, and as would be expected, health decreases with age. This format has less validity for older people of extreme age and it is suggested that a face to face assessment for this age group would be more appropriate. It is also pertinent that alongside the questionnaire, practices should be aware of any existing knowledge they may have with regard to older people in their practice population, since the results have shown that 3-5% of the targeted population may

‘fall through the net’, with the questionnaire having proved unreliable.

Self-assessment questionnaires should contain an explanatory note for patients, and patients should be reassured that they may choose to have a face to face assessment if that is what they wish, regardless of the outcomes of the questionnaire.

It is difficult to assess the effect of preventative strategies on meeting government targets. Within the new GMS Contract (DH, 2003) there is little reference to the care of older people. However, the targets around the management of chronic diseases encourage practices to seek out and support those patients most at risk. At the same time, identifying those patients with potential problems, may avoid crisis intervention in the future and subsequently prevent unnecessary hospital admission.

There is little doubt that there are implications of increased cost in terms of the screening process, the manpower resources and subsequent management of any issues identified (Kestin and Savage, 1990). Ethically, if a screening process is initiated, then there must be a clearly defined rationale for it. Merely identifying problems where there is no benefit to the patient, or raising expectations where there is no available intervention, is unacceptable in terms of the use of scarce resources, patient time and risks to patient care (McGarry, 1999).

REFERENCES

- Arthur, A. (2000). *Late Life Depression: a structured approach to identification and management by the Primary Care Team*. University of Leicester: Unpublished PhD Thesis.
- Assessment & Intelligence Systems (AIS). (2002). *Minimum Data Set-Home Care*. Surrey, UK.
- Assessment & Intelligence Systems (AIS). (2002a). *Minimum Data Set-Home Care*. Manitoba, Canada.
- Barber, J.H., Wallis, J.B., McKeating, E. (1981). A postal screening questionnaire in preventive geriatric care. *Journal of the Royal College of General Practitioners*. 31, 51-54.
- Beauchamp, T.L., & Childress, J.F. (2001). *Principles of Biomedical Ethics*. Fifth edition. Oxford: Oxford University Press.
- Becker, M.H., & Rosenstock, I.M. (1984). *Compliance with medical advice*. In A. Steptoe & A. Matthews (ed.), *Health care and human behaviour*. London: Academic Press. Pages 135-152.
- Benyamini, Y., Idler, E.L., Leventhal, H., Leventhal, E.A. (2000). Positive affect and function as influences on self-assessments of health: Expanding our view

beyond illness and disability. *The Journals of Gerontology: Series B Psychological sciences and social sciences*, 55B(2), 107-116.

Birnie, S. (2001). *Elderly Health Assessments – Chester City Practices*. Chester: Unpublished.

Brody, K., Johnson, R., Reid, L. (1997). Evaluation of a Self-Report Screening Instrument to Predict Frailty Outcomes in Aging Populations. *The Gerontologist*, 37(2), 182-191.

Bryman, A. (2001). *Social Research Methods*. Oxford: Oxford University Press.

Buxton, P. (2000). *Executive Summary: Early Contact Project*. Age Concern: Unpublished.

Carpenter, G.I. (2004). *The Single Assessment Process and the MDS-HC*. Retrieved September 5th, 2004, from:
<http://www.aissystems.ltd.uk/PDF/SAPandMDS-HC.pdf>

Champion, V.L. (1984). Instrument development for health belief model constructs. *Advances in Nursing Science*, 6, 73-85.

Cheshire Rural Primary Care Group. (2002). *Elderly Health Assessment*. Unpublished

Dahlgren, G., Whitehead, M. (1991). *Policies and strategies to promote social equity in health*. Stockholm: Institute for Further Studies.

Data Protection Act. (1998). London: HMSO.

Department of Health and the Welsh Office (1989). *General Practice in the National Health Service: A New Contract*. London: HMSO.

Department of Health (1990). *National Health Service and Community Care Act 1990*. London: HMSO.

Department of Health. (1997). *Caldicott Report*. London: HMSO.

Department of Health. (2001). *National Service Framework – Older People*. London: HMSO.

Department of Health. (2001a). *Research Governance Framework for Health and Social Care*. London: HMSO.

Department of Health. (2002). *The Single Assessment Process – Guidance for Local Implementation*. London: HMSO.

Department of Health. (2003). *Investing in General Practice: the New General Medical Services Contract*. London: HMSO.

- Donald, I., Bulitt, C. (1998). The Gloucestershire longitudinal study of disability outcomes in non-responders, responders and subsequent defaulters. *Journal of Clinical Epidemiology*. 51(12), 1305-1310.
- Dutton, K. (2002). *The Feasibility of Implementing the Single Assessment Process for Older People using the Minimum Data Set-Home Care (MDS-HC). A Pilot Study Examining the Role of the Contact Assessment*. Unpublished.
- Fletcher, A.E., Price, G.M., Edmond, S.W. Ng., Stirling, S.L. et al (2004). Population-based multidimensional assessment of older people in UK general practice: a cluster-randomised factorial trial. *The Lancet*, 364, 1667-1677.
- Fries, B.E., James, M., Hammer, S.S., Shugarman, L.R., Morris, J.N. (2004). Is telephone screening feasible? Accuracy and cost-effectiveness of identifying people medically eligible for home- and community-based services. *The Gerontologist*, 44 (5), 680-688.
- Garrett, G. (1992). Health Screening for Elderly People. *Nursing Standard*, 40, 25-27.
- Gelling, L. (1999). Role of the Research Ethics Committee. *Nurse Education Today*, 19, 564-569.
- Glaser, B., Strauss, A. (1967). *The discovery of Grounded Theory*. Chicago: Aldine.

- Gould, M., Iliffe, S., Wallace, P. (2000). Primary care for older people: a study of innovative practices. *Community Practitioner*, 73(7), 682-684.
- Grau, L., West, B., Gregory, P. (1998). "How do you feel?" Self-Reported Health as an Indicator of Current Physical and Mental Health Status. *Journal of Psychological Nursing & Mental Health Services*, 36(6), 24-30.
- Gudmundsson, A., Carnes, M. (1996). Geriatric assessment: Making it work in primary care practice. *Geriatrics*, 51(3), 55-57.
- Hammond, J., Iliffe, S., Elliott, D. (2002). The NSF for Older People: a market town experience. *Community Practitioner*, 75(6), 211-213.
- Hébert, R., Bravo, G., Korner-Bitensky, N., Voyer, L. (1996). Predictive validity of a postal questionnaire for screening community dwelling elderly individuals at risk of functional decline. *Age and Ageing*, 25(2), 159-167.
- Hébert, R., Robichaud, L., Roy, P-M., Bravo, G., Voyer, L. (2001). Efficacy of a nurse-led multidimensional preventive programme for older people at risk of functional decline. A randomised controlled trial. *Age and Ageing*, 30(2), 147-153.
- Hedley, R., Ebrahim, S., Sheldon, M. (1986). Opportunities for anticipatory care with the elderly. *Journal of Family Practice*, 22(2), 141-145.

Iliffe, S., Haines, A., Gallivan, S., Booroff, A., Goldenberg, E., Morgan, P. (1991) Assessment of elderly people in general practice. 2. Functional abilities and medical problems. *British Journal of General Practice*, 41(342), 9-12.

Iliffe, S., Gould, M.M., Wallace, P. (1997) *Evaluations of the 75 year old and over checks; report 1 examples of good practice and their implications for future policy*. London: Department of Primary Health Care.

Iliffe, S., Gould, M., Wallace, P. (1999). Assessment of older people in the community: lessons from Britain's '75 and over' checks. *Reviews in Clinical Gerontology*, 9(4), 305-316.

International Council of Nurses (ICN). (1996). *Ethical Guidelines for Nursing Research*. Geneva: ICN.

Kelly-Hayes, M., Jette, A.M., Wolf, P.A., D'Agostino, R.B., Odell, P.M. (1992). Functional limitations and disability among elders in the Framingham study. *American Journal of Public Health*, 82, 841-845.

Kempen, G.I.J.M., Steverink, N., Ormel, J., Deeg, D.J.H. (1996). The assessment of ADL among frail elderly in an interview survey: Self-report versus performance-based tests and determinants of discrepancies. *The Journals of Gerontology: Series B Psychological sciences and social sciences*, 55B(5), 254-260.

Kestin, K.J., Savage, R.V. (1990). Geriatric screening in a rural practice: the financial implications. *British Journal of General Practice*, 40(341), 513-515.

Lee, Y. (2000). The predictive value of self assessed general, physical, and mental health on functional decline and mortality in older adults. *Journal of Epidemiology and Community Health*, 54(20), 123-129.

Lum, T.Y., Lin, W-C., Kane, R.L. (2005). Use of Proxy Respondents and Accuracy of Minimum Data Set Assessments of Activities of Daily Living. *The Journals of Gerontology*, 60A(5), 654-659.

Mallinson, S. (1998). The Short-Form 36 and older people: some problems encountered when using postal administration. *Journal of Epidemiology and Community Health*, 52(5), 324-328.

Matsubayashi, K., Okumiya, K., Osaki, Y., Fujisawa, M., Doi, Y. (1997). Quality of life of old people living in the community. *The Lancet*, 350(9090), 1521-1522.

McGarry, J. (1999). Can over-75 health checks identify unmet need? *Nursing Standard*, 13(33), 37-39.

McIntosh, I.B., Young, M., Stewart, T. (1988). General practice geriatric surveillance scheme. *Scott Med J*. 33(5), 332-3.

Miller, J., Birnie, S., Dutton, K., Elliott, P. (2004). Implementing the single

assessment process using the Minimum Data Set–Home Care: a pilot study. *Nursing Older People*, 16(9), 14-18.

National Statistics Online. (2004). *Census 2001*. Retrieved 15 September, 2004, from <http://www.statistics.gov.uk>

Noakes, L. (2002). *Cheshire West Primary Care Trust: Primary Care Development Briefing Paper*. Unpublished.

Nursing and Midwifery Council (NMC). (2002). *Code of Professional Conduct*. London: NMC.

Ormel, J., Kempen, G.I.J.M., Steverink, N., van Eijk, B.J.M., Brilman, E.I., Wolffensperger, E.W., Meyboom-de Jong, B. (1992). The Groningen Longitudinal Aging Study on functional status and need for care; outline of a NESTOR research program. Groningen, The Netherlands: Northern Centre for Health Care Research, University of Groningen, *cited in* Kempen, G.I.J.M., Steverink, N., Ormel, J., Deeg, D.J.H. (1996). The Assessment of ADL Among Frail elderly in an Interview Survey: Self-report versus Performance-Based Tests and Determinants of Discrepancies. *The Journals of Gerontology: Series B Psychological sciences and social sciences*, 55B(5), 254-260.

Parahoo, K. (1997). *Nursing Research: Principles, Process and Issues*. Basingstoke: Macmillan.

Pathy, M.S.J., Bayer, A., Harding, K., Dibble, A. (1992). Randomised trial of case finding and surveillance of elderly people at home. *Lancet*, 340, 890-893.

Philp, I., Newton, K.J., Dixon, S., Rowse, G., Bath, P.A. (2001). Geriatric assessment in primary care: formulating best practice. *British Journal of Community Nursing*, 6(6), 290-295.

Punch, K.F. (2000). *Developing Effective Research Proposals*. London: Sage Publications.

Sager, M.A., Dunham, N.C., Schwantes, A., Mecum, L., Halverson, K., Harlowe, D. (1992). Measurement of activities of daily living in hospitalized elderly: a comparison of self report and performance based measures. *Journal of the American Geriatrics Society*, 40, 447-462.

Seddon, D. (1998). *The health of older people*. Public Health Policy Team: South Cheshire Health Authority.

Smeeth, L., Fletcher, A.E., Stirling, S., Nunes, M., Breeze, E., Ng, E., Bulpitt, C.J., Jones, D. (2001). Randomised comparison of three methods of administering a screening questionnaire to elderly people: findings from the MRC trial of the assessment and management of older people in the community. *British Medical Journal*, 323(7326), 1403-1407.

Strauss, A., Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. California: Sage.

Stuck, A.E., Beck, J.C., Egger, M. (2004). Preventing disability in elderly people. *The Lancet*, 364, 1641-1642.

Townsend, P., Phillimore, P. and Beattie, A. (1988). *Health and Deprivation: Inequality and the North*. London: Routledge.

van Haastregt, J., Diedericks, J., Van Rossum, E., DeWitte, L., Crebolder. H. (2000). Effects of preventative home visits to elderly people living in the community: a systematic review. *British Medical Journal*. 320, 754-758.

Walters, K., Iliffe, S., Tai, S.S., Orrell, M. (2000). Assessing needs from patient, carer and professional perspectives: the Camberwell Assessment of Need for Elderly people in primary care. *Age and Ageing*, 29(6), 505-510.

APPENDIX 1

The Single Assessment Process

Standard Two of the NSF for Older People (DH, 2001) reflects a national commitment to 'person centred care', for organisations to consider levels of assessment based on the needs of each individual, as opposed to a 'one size fits all' approach.

Department of Health guidance on the Single Assessment Process lays down 'best practice' guidelines as to the areas that should be taken into consideration when assessing patients in order to gain the most useful outcomes in terms of health and social services support.

The Single Assessment Process suggests types of assessment appropriate to the needs of the older person. The Contact assessment occurs at the initial 'contact' an older person has with health or social services, during which certain information is gathered – this includes:-

- the nature of the presenting problem;
- the significance for the older person;
- the duration of the problem;
- potential solutions identified by the older person;
- other problems experienced;
- recent relevant life events;
- the perception of family and carers

During the Overview assessment, all, or most of the domains as laid down in the 'best practice' evidence, are explored (DH, 2001). This may be sufficient to fully describe a person's needs; may trigger areas where further assessment is required; or may occur as soon as basic personal information has been collected. The Specialist assessment requires the exploration of specific domains as indicated by either contact or overview assessment, including the involvement and judgement of appropriately qualified and experienced professionals and may require the use of specific tools and scales i.e. Geriatric Depression scale; Occupational Therapy assessments; etc.

A comprehensive assessment will be required for all older people where the level of support and treatment likely to be offered is intensive and complex (including permanent admission to a care home, intermediate care facilities, or intensive packages of care at home)

An older person may be assessed at any level depending on their needs, and indeed, a comprehensive assessment may be necessary following initial contact if needs are perceived by the professional to be complex and multiple. The extent of their needs may however, only become apparent, following an overview assessment. The Department of Health's view is that anyone, including older people themselves, should be capable of carrying out the contact assessment, with all health and social services professionals being able to complete the overview assessment.

APPENDIX 2

CONTACT ASSESSMENT – SELF-ASSESSMENT QUESTIONS USED IN PILOT PROJECT 2001

1. Do you manage to organise your daytime activities?
If not, what help do you have and who gives this?
2. Do you make your own meals?
If not, what help do you have and who gives this?
3. Do you manage to do your own housework, e.g. cleaning, laundry, and bed making?
If not, what help do you have and who gives this?
4. How often do you get out in a typical month?
What activities do you do, and what transport do you use?
5. Do you manage to do your own personal care e.g. dressing, washing, cleaning teeth, and getting to the toilet?
If not, what help do you have and who gives this?
6. Do you manage to bath/shower or have a body wash yourself?
If not, who helps with this and how?
7. Do you take part in any physical activities e.g. walking, cleaning house, exercises?
What activities do you do and how often?

APPENDIX 3

ANALYSIS OF CONTACT ASSESSMENT QUESTIONS – USED IN PILOT PROJECT 2001

1. Patient answers all the questions.
2. **Self Reliant** - - BOTH the following criteria are met:
 - Answered YES in Question One (Daily Decision Making)
 - AND answered YES in at least THREE of the other questions
3. **NOT Self Reliant** - - EITHER of the following criteria are met:
 - Answered NO in Question One (Daily Decision Making)
 - Answered YES on TWO OR LESS of the other questions

If Self Reliant, do not need to do any further assessment

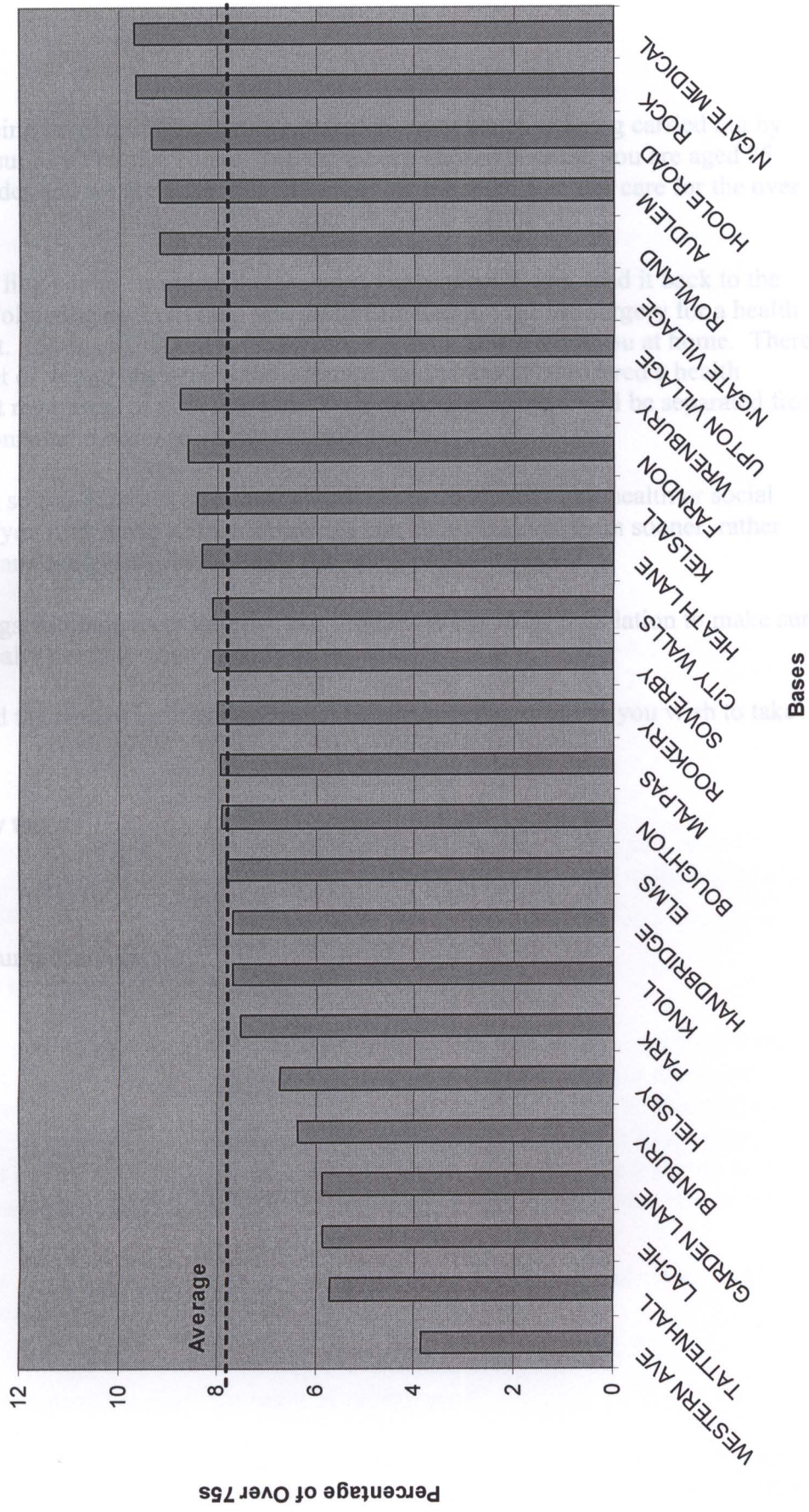
If NOT Self-Reliant, or there is no response to any of the questions, further action is required. If not self reliant then go on to do a fuller assessment. In order to fully comply with the DH Single Assessment Process Guidance, you will need to ensure all the domains are covered as described in the guidance.

APPENDIX 4

DOMAINS OF THE SINGLE ASSESSMENT PROCESS

- User's perspective
 - Problems and issues in the user's own words
 - Self rated health
 - User's expectations and motivation
- Clinical background
 - History of medical problems
 - History of falls
 - Medication use
- Disease prevention
 - History of blood pressure monitoring
 - Nutrition
 - Vaccination history
 - Drinking and smoking history
 - Exercise pattern
 - History of cervical and breast screening
- Personal care & physical well-being
 - Personal hygiene, including washing, bathing, toileting and grooming
 - Dressing
 - Pain
 - Oral care
 - Foot care
 - Tissue viability
 - Mobility
 - Continence
 - Sleeping patterns
- Senses
 - Sight
 - Hearing
 - Communication
- Mental health
 - Cognition, including dementia
 - Mental health, including depression
- Relationships
 - Social contacts, relationships and involvement
 - Caring arrangements
- Safety
 - Abuse or neglect
 - Other aspects of personal safety
 - Public safety
- Immediate environment and resources
 - Care of the home
 - Accommodation
 - Access to local facilities and services

Percentage Population Over 75



APPENDIX 6

Dear

You are being invited to take part in a research study which is being carried out by your own surgery Practice Nurse. You have been chosen because you are aged 75 years or older and we are interested in improving the quality of our care for the over 75s'.

We would like you to complete the enclosed questionnaire, and send it back to the surgery. Following on from that, you will be invited to visit the surgery for a health assessment. If you cannot come to the surgery, a nurse will visit you at home. There are no right or wrong answers to the questions and you will be offered a health assessment regardless of your answers. Your name and address will be separated from the questionnaire in order to ensure confidentiality.

By using a self-assessment questionnaire, we hope to identify any health or social needs that you may have, so that something can be done about them sooner, rather than later; and preferably, before they become a problem to you.

The findings will help us to improve our service for our older population to make sure all your health needs are met as early as possible.

Please read the patient information leaflet before deciding whether you wish to take part.

With many thanks

Practice Nurse Manager

Practice A

Patient Information Sheet

“SELF-ASSESSMENT IN THE OVER 75S”

What is the purpose of this study?

You are being invited to take part in a research study by participating in answering the enclosed questionnaire. These simple questions are to identify people who would benefit from further health assessment.

What do we mean by Health Assessment?

A health assessment will provide us with information to help find out the current status of your health.

Why have I been chosen?

You have been chosen because you are aged 75 years or older. Other patients from your practice who have reached the ages of 75, 85 or 95 within this year are also being asked to take part in this study. This project will last for one year.

Do I have to take part?

It is up to you to decide if you wish to take part. A decision to take part or not, will not adversely affect in any way, the standard of health care you are receiving now or in the future.

What will happen to me if I take part?

If you take part in this study, you will need to fill in the enclosed questionnaire and then post it back to your surgery (in the enclosed envelope) with your name and address, plus the signed consent form. The questionnaire will then be assessed by your practice nurse who will ask you to visit the surgery for a health assessment. If you cannot come to the surgery, a nurse will visit you at home. There are no right or wrong answers to the questions and you will be offered a health assessment regardless of your answers.

Your name and address will be separated from the questionnaire and coded in order to ensure anonymity.

What are the possible disadvantages of taking part?

There are no disadvantages or risks foreseen in taking part in the study. **However, if you are worried or require more information, please phone your surgery and ask**

to speak to the Practice Nurse. If she is not free at that time, she will phone you back.

What are the benefits of taking part?

There are no direct benefits to taking part, but as a patient we would welcome your input so that we can improve the quality of the service provided by the practice for the over 75s'.

We will discuss with you the outcome of your assessment, and should any concerns be raised, these will be referred to the appropriate service as per normal care.

We will also discuss with you ways in which to help maximise your health and social well being.

What will happen to the results?

The findings will help us to improve our service for our older population to make sure all your health needs are met as early as possible.

Will the information I give be confidential?

All information collected about you during the course of the research will be kept strictly confidential. Your name will not be mentioned in any reports.

THANK YOU FOR READING THIS.

IF YOU HAVE ANY QUESTIONS OR PROBLEMS, EITHER RELATING TO THE PROJECT OR IN FILLING IN THE QUESTIONNAIRE, BUT WOULD STILL LIKE TO TAKE PART IN THE STUDY, PLEASE CONTACT:

..... – TEL. NO. 01244

CONSENT FORM

Title of Project: Self-assessment in the Over 75s'

Name of Researcher:.....

I agree to take part in this project, which will be carried out by staff from within my own GP practice.

My signature on the bottom of this form shows that:

Please initial box

I have read and understand the information sheet provided and have had the opportunity to ask questions.

I understand that my participation is confidential and that my name will not be mentioned in any report.

I understand that my taking part in this project is voluntary and that I can decide against being involved in the project at any time. I know I don't have to give reasons.

I understand the researcher will look at my records.

I understand that participation in this study does not affect my rights to seek health care as and when I require

_____	_____	_____
Name of Patient	Date	Signature

_____	_____	_____
Name of person taking consent (if different from Researcher)	Date	Signature

_____	_____	_____
Researcher	Date	Signature

PRACTICE A

THE REASONS FOR ASKING THESE QUESTIONS ARE COVERED IN THE ATTACHED INFORMATION LETTER.

PLEASE FEEL FREE TO ANSWER THEM YOURSELF OR ASK FOR ASSISTANCE FROM FAMILY OR FRIENDS.

WE ARE MOST GRATEFUL FOR YOUR HELP IN THIS RESEARCH PROJECT.

PLEASE INDICATE THE MOST APPROPRIATE ANSWER TO EACH OF THE FOLLOWING QUESTIONS AND WRITE IN YOUR COMMENTS

1. Do you manage to organise your daytime activities? YES ☐ NO ☐
If not, what help do you have and who gives this?

2. Do you make your own meals? YES ☐ NO ☐
If not, what help do you have and who gives this?

3. Do you manage to do your own housework, e.g. cleaning, laundry, and bed making? YES ☐ NO ☐
If not, what help do you have and who gives this?

4. How often do you get out in a typical month? _____ TIMES
What activities do you do, and what transport do you use?

5. Do you manage to do your own personal care e.g. dressing, washing, cleaning teeth, and getting to the toilet?

YES ☐ NO ☐

If not, what help do you have and who gives this?

6. Do you manage to bath/shower or have a body wash yourself?

YES ☐ NO ☐

If not, who helps with this and how?

7. Do you take part in any physical activities e.g. walking, cleaning house, exercises?

YES ☐ NO ☐

What activities do you do and how often?

✂-----

THANK YOU FOR COMPLETING THIS FORM. PLEASE RETURN TO
YOUR GP SURGERY IN THE ENVELOPE PROVIDED.

YOUR NAME.....

YOUR ADDRESS.....

.....

.....

NAME OF PERSON COMPLETING FORM IF DIFFERENT FROM ABOVE

.....

RELATIONSHIP TO PATIENT:.....

APPENDIX 7

ANALYSIS OF CONTACT ASSESSMENT QUESTIONS (Completed questionnaires only)

Contact Assessment

1. Patient answers all the questions.
2. **Self Reliant** - - BOTH the following criteria are met:
 - Answered YES in Question One (Daily Decision Making)
 - AND answered YES in at least THREE of the other questions
3. **NOT Self Reliant** - - EITHER of the following criteria are met:
 - Answered NO in Question One (Daily Decision Making)
 - Answered YES on TWO OR LESS of the other questions

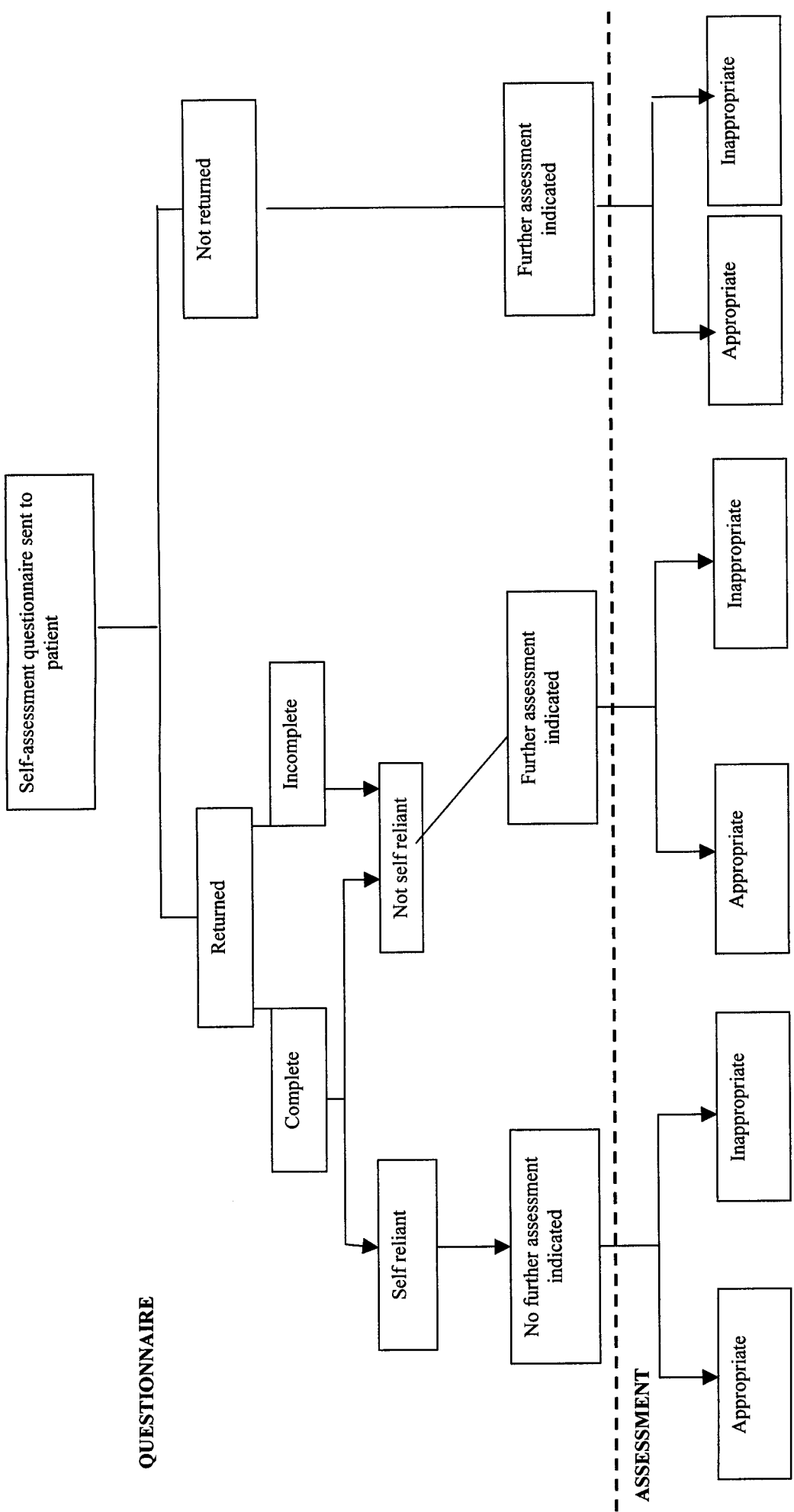
If Self Reliant, do not need to do any further assessment

If NOT Self Reliant, or there is no response to any of the questions, further action is required

Overview Assessment

If not self reliant then go on to do a fuller assessment. In order to fully comply with the DH Single Assessment Process Guidance, you will need to ensure all the domains are covered as described in the guidance.

ALGORITHM FOR ANALYSIS OF RESPONSE TO SELF-ASSESSMENT QUESTIONNAIRES



APPENDIX 9**Consulting patients on their views about 'Self-assessment in the Over 75s'****Interview schedule**

Semi-structured, in-depth interviews have a 'loose' structure consisting of open-ended questions that define the area to be explored, but allow the interviewer or interviewee to diverge in order to follow up particular areas in more detail (Britten, 1995). Thus, although the interview topics and questions below have been defined initially, the semi-structured format will allow interviewees to express ideas that are important to them, and will enable answers to be clarified and more complex issues probed than would be possible using a more structured approach. This interview schedule has been written primarily as a guide to the researcher, but the actual language used by the researcher when interviewing participants will be modified in practice to be more culturally sensitive.

Patient's feelings on receiving questionnaire

How did you feel about receiving this questionnaire from your GP?

- Did they feel concern about filling in the questionnaire?
- Did they feel happy to fill in the questionnaire?
- Did they understand why they had received the questionnaire?

Patient's understanding of questions

How easy did you find the questions to understand?

- Did they feel the wording of the questions difficult to understand?
- Were there any questions they found upsetting or offensive?

Patient's understanding of purpose of questionnaire

For what purpose do you think these particular questions were asked?

- Did they understand the aims of the study?

Process of assessment

How would you feel if you received these questions only, and then did not receive a full health assessment as a result of your answers?

- Would they feel let down?
- Would they feel that an adequate assessment of their needs had taken place?

Perception of health

What steps would you like to take to increase your health?

- Explore their perceptions of their own health
- What barriers are in the way of achieving health goals?

APPENDIX 10

GP Information Sheet

“Self-assessment in the Over 75s”

Since the 1990 GP service agreement, GPs have been obliged to offer all patients over the age of 75 years, an annual medical check up. This was to not only encompass those patients who were able to attend the GP surgery, but also the housebound, as well as those patients living in residential and nursing homes. In 2000, Buxton, through a project carried out by Age Concern, discovered that there was both anecdotal and research evidence to show that health checks for the elderly are widely ignored by health professionals. This was reported as being mainly due to inconclusive evidence of any research with a sound scientific basis supporting the effectiveness of such check ups. The evidence in Cheshire West suggests that most practices have some sort of ‘over 75’ check, but none are standardised (Birnie 2001).

Guidance from the DOH on the Single Assessment Process does not affect the obligations of GPs to offer a health check, on at least an annual basis, to all people aged 75 and over on their practice list.

Although further guidance on the ‘over 75’ health check and the relationship with the Single Assessment Process will be issued in 2003, in the meantime, it is useful to review the ‘over 75’ health check in light of the domains of the Single Assessment Process. This lays down ‘best practice’ guidelines as to the areas that should be considered when assessing patients to gain the most useful outcomes in terms of health and social services support.

Anecdotal evidence suggests that in practices in Chester where ‘over 75’ health checks are offered, but not taken up by all patients in that category, those who do attend are often those patients who are already proactive about their health, although this is obviously not always the case. It would seem that in a number of practices patients who would probably benefit the most from a health check never receive one.

The seven ‘contact’ assessment questions in the MDS-HC assessment proforma provide indicators of need for further assessment or intervention and may provide a basis from which decisions can be made about which patients in a practice would derive most benefit from a fuller assessment.

With this in mind, Practice A has been selected to take part in a research project to evaluate the validity of the ‘contact’ questions as a self-assessment screening tool for the selection of patients who require further assessment of their health needs, as a way of rationalising and targeting the ‘over 75’ health assessment at those patients who would derive the most benefit from such interventions.

The project is being carried out in conjunction with the Clinical Nurse Specialist (Elderly), Cheshire West PCT. **will lead the project for Practice A.** Practice B will be the other practice taking part.

It is envisaged that the outcomes from the project will inform future assessment and health promotion for the 'over 75' population in general practice across Cheshire West PCT, in line with the guidance around the Single Assessment Process and also enable practices to develop a profile of their vulnerable elderly.

The proposed procedure for the project is as follows:

- Commencing April/May 2003 for a period of one year.
- A self-assessment questionnaire will be sent from the practice to every patient who reaches the age of 75, 85 or 95 during the year of the project. (enc.)
- The patient will be given one month to complete and return the questionnaire. Each patient will also receive a patient information leaflet and consent form.
- *The Practice Nurse* will collate the outcomes of the questionnaire according to the protocol. (enc.)
- The patient will then be invited to either attend the surgery for a follow up assessment, or *the Practice Nurse* will visit them at home (including those in residential or nursing home accommodation).
- A fuller holistic assessment will then be completed, which will include all the domains as outlined in the overview assessment of the Single Assessment Process.
- *The Practice Nurse* will complete any further investigations or referrals that may arise as a result of this assessment.
- She will also consider the outcome of the assessment with the results of the initial questionnaire for each patient, in order to evaluate the validity of the self-assessment screening tool for selecting patients who require further assessment of their health needs.

If you would like to see the full project proposal, or have any questions or problems please contact:

.....

Thank you for taking the time to read this. Please sign the consent form below to acknowledge your agreement to the project-taking place within your practice.

Enc. Questionnaire
Protocol
Patient information leaflet and consent form

CONSENT FORM

Title of Project: Self-assessment in the Over 75s'

Name of Researcher:.....

Please initial box

I have read and understand the information sheet provided and agree to the research project taking place in my practice. ☐

I agree to continue to treat any patients who are taking part in the research according to the usual practice protocols ☐

I understand that participation in the study does not affect the patients' right to seek healthcare as and when required. ☐

<hr/>	<hr/>	<hr/>
Name of GP	Date	Signature
<hr/>	<hr/>	<hr/>
Name of person taking Consent (if different from researcher)	Date	Signature
<hr/>	<hr/>	<hr/>
Researcher	Date	Signature

Copies: 1 for GP and 1 for Researcher

APPENDIX 11

Reasons for non-participation

	Practice A			Practice B		
	75s	85s	95s	75s	85s	95s
Refusal to participate in study	10	5	2	1	0	0
Unable to give consent	1	1	1	0	0	0
Moved out of area	1	1	0	1	0	0
Died	0	0	0	0	1	0
Completed questionnaire but did not attend follow up assessment	3	4	1	0	1	1
TOTAL	15	11	4	2	2	1

REASONS GIVEN FOR REFUSAL TO TAKE PART IN STUDY

- Did not want to be involved (6)
- Terminally ill (1)
- Left area (1)
- Seeing enough people already – patient statement (4)
- Under psychiatrist – unable to get consent (2)
- Unable to contact, often out – despite visiting and phoning (2)
- Form returned complete but did not want further involvement (6)
- Form returned, unable to contact for follow up appointment (4)

APPENDIX 12

Self reliant but did not attend follow up assessment

Reasons for not attending follow up assessment	No. of participants
Seen regularly, did not wish further assessment	1
Unable to contact	3
Refused	5
Unable to gain consent	1
TOTAL	10

APPENDIX 13

**REASONS GIVEN FOR NOT RETURNING QUESTIONNAIRE BUT
SUBSEQUENT ATTENDANCE FOR FOLLOW UP ASSESSMENT**

- No reason given - 3
- Very recent bereavement - 1
- Had not got around to posting it back to surgery - 2
- Too busy - 2

APPENDIX 14

Interviewees Comments

Interviewee's feelings on receiving the questionnaire

"...sending it out to various people" (Interview 1)

"...for the records, to help." (Interview 2)

"...from Sister [name] to find out about me at home" (Interview 3)

"...to check on older people" (Interview 4 & 5)

"...to keep in touch as I don't come to the doctor regularly" (Interview 6)

"...I was one of the lucky ones" (Interview 13).

Interviewee's understanding of purpose of questionnaire

"...I can't remember one day to the next sometimes."

"...you wanted to find out if I was bed-ridden and what I could do around the house, what I couldn't do, and anything I couldn't do I would have assumed I would have been getting help for, so as far as I'm concerned it was an excellent idea all round." (Interview 1)

"To help staff know how to deal with the elderly" (Interview 4)

"...to keep a check on older people" (Interview 5)

"To improve services and to understand the problems people come up against as they get older." (Interview 7)

"Well, I think you were trying to get as much information as you could with regards to the project you were doing." (Interview 8)

"...you were trying to evaluate your older patients and ..." (Interview 10)

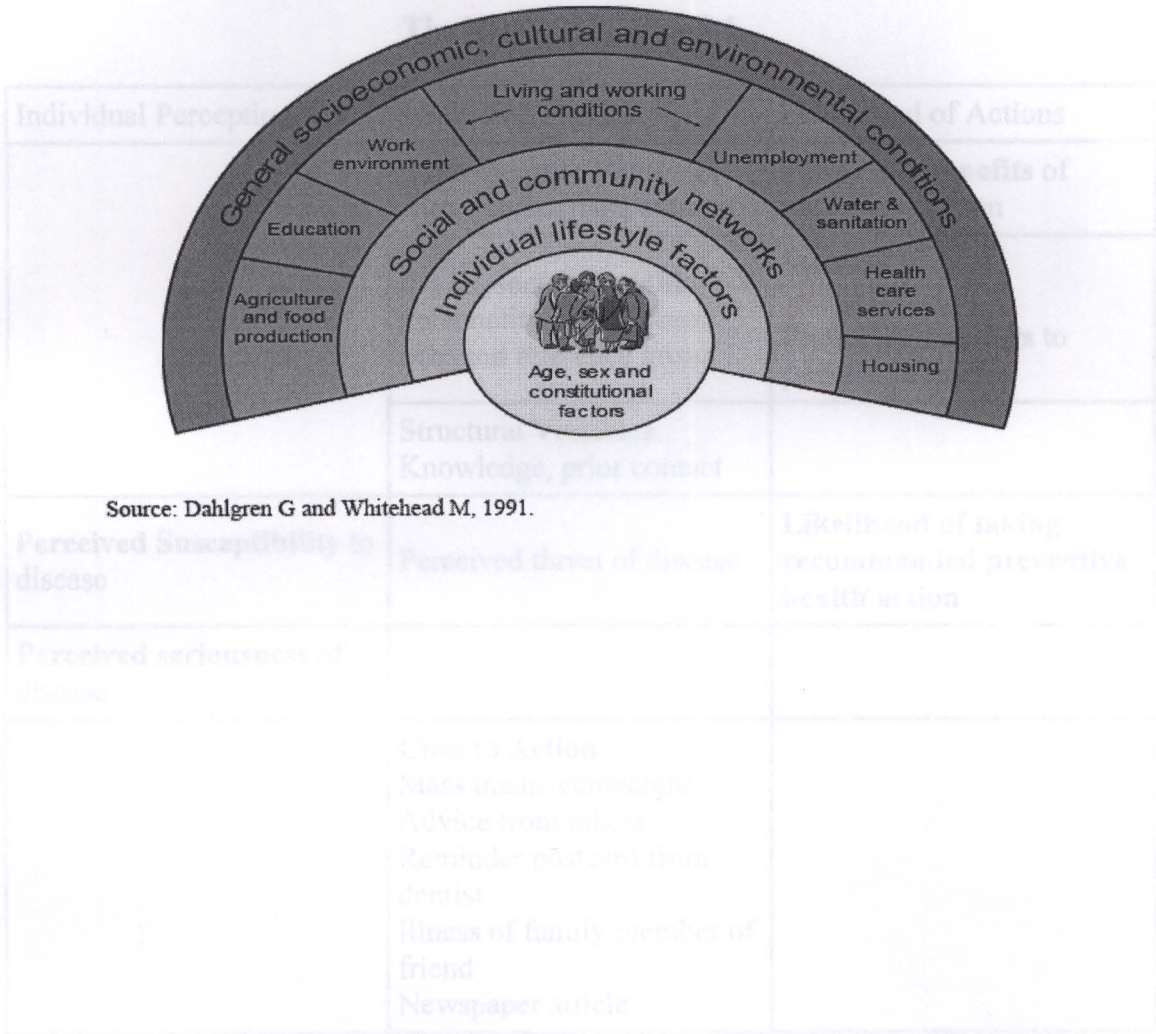
Process of assessment

"...I think it was far better to be called in" (Interview 10)

"No, I think it's better this way, that you've done, because it enables you to ask questions back doesn't it? If you don't understand anything" (Interview 11)

APPENDIX 15

Figure 1 Factors Influencing Health



Source: Dahlgren G and Whitehead M, 1991.

The health belief model is adapted from Becker and Rosenstock 1984

APPENDIX 16

The Health Belief Model

Individual Perceptions	Modifying Factors	Likelihood of Actions
	Demographic Variables Age, gender, race, ethnicity	Perceived Benefits of preventive action
	Psychosocial Variables Personality, social class, peer and reference group	MINUS Perceived barriers to preventive action
	Structural Variables Knowledge, prior contact	
Perceived Susceptibility to disease	Perceived threat of disease	Likelihood of taking recommended preventive health action
Perceived seriousness of disease		
	Cues to Action Mass media campaigns Advice from others Reminder postcard from dentist Illness of family member of friend Newspaper article	

The health belief model is adapted from Becker and Rosenstock 1984

TARGETING THE VULNERABLE ELDERLY AND THE SINGLE ASSESSMENT PROCESS IN GENERAL PRACTICE - ON GOING PRACTICE

